101-37

REIMBURSEMENT UNDER THE MEDICARE PROGRAM FOR HOSPITAL CAPITAL EXPENSES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

H.R. 712

TO AMEND TITLE XVIII OF THE SOCIAL SECURITY ACT WITH RESPECT TO PAYMENT FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES UNDER THE MEDICARE PROGRAM

MARCH 13, 1989

Serial 101-37

Printed for the use of the Committee on Ways and Means

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REIMBURSEMENT UNDER THE MEDICARE PROGRAM FOR HOSPITAL CAPITAL EXPENSES

MONDAY, MARCH 13, 1989

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:10 p.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing and the bill, H.R. 712, follow:]

FOR IMMEDIATE RELEASE
THURSDAY, FEBRUARY 23, 1989

PRESS RELEASE #4
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON REIMBURSEMENT UNDER THE MEDICARE PROGRAM FOR HOSPITAL CAPITAL EXPENSES, INCLUDING H.R. 712, THE MEDICARE INPATIENT HOSPITAL CAPITAL EXPENDITURE AMENDMENTS OF 1989

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on reimbursement under the Medicare program for hospital capital expenses, including H.R. 712, the Medicare Inpatient Hospital Capital Expenditure Amendments of 1989. The hearing will be held on Monday, March 13, 1989, beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

It is estimated that Medicare's aggregate payments to hospitals for capital expenditures will rise at an average rate of 11 percent per year between 1989 and 1993. This will raise Medicare capital payments per case from $482 to $661, an increase of 37 percent, during that period.

Average occupancy for hospitals is now just over 64 percent for staffed beds, having dropped from a level of about 75 percent over the last decade. Fifty-four percent of all hospitals have an occupancy rate below 50 percent, and only five percent of hospitals have an occupancy rate above 80 percent.

The prospective payment system (PPS) was adopted in 1983 as the method of payment of hospital operating costs. Payment for capital-related expenses (depreciation, interest, and return-on-equity) was not included in PPS due to uncertainty about the impact of including capital reimbursement in the system. Capital continues to be reimbursed on a retrospective cost basis, except that payments are reduced by 15 percent in fiscal year 1989. The Administration has proposed to extend and expand the reduction to 25 percent in fiscal year 1990.

Congress directed the Secretary of Health and Human Services to study and report to the Congress on a proposal to include capital in the prospective payment system. The report was submitted in March 1986, proposing a system for capital costs which would pay hospitals a flat amount per Medicare admission based upon the actual national average capital payment per admission at that point in time. This system was to be implemented October 1, 1986. Given concerns about the impact of this proposal on specific hospitals, Congress first delayed its implementation until October 1, 1987, and then again until October 1, 1991.

(MORE)

During the same period, Federal support for capital review programs was ended, although 31 States continue to review hospital capital expenditures under State authority.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, March 24, 1989, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * NOTICE -- CHANGE IN LOCATION * * *

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 7, 1989

PRESS RELEASE #4-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A CHANGE IN THE ROOM FOR THE HEARING ON REIMBURSEMENT UNDER THE MEDICARE PROGRAM FOR HOSPITAL CAPITAL EXPENSES, INCLUDING H.R. 712, THE MEDICARE INPATIENT HOSPITAL CAPITAL EXPENDITURE AMENDMENTS OF 1989

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the room for the Subcommittee's hearing on reimbursement under the Medicare program for hospital capital expenses, including H.R. 712, the Medicare Inpatient Hospital Capital Expenditure Amendments of 1989, has been changed.

The hearing scheduled on Monday, March 13, 1989, beginning at 1:00 p.m., will now be held in the Main Committee hearing room, 1100 Longworth House Office Building, instead of room B-318 Rayburn House Office Building as announced earlier.

All other details for the hearing remain the same (see press release #4, dated February 23, 1989).

* * * * *

I

101ST CONGRESS
1ST SESSION

H. R. 712

To amend title XVIII of the Social Security Act with respect to payment for capital-related costs for inpatient hospital services under the medicare program.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 27, 1989

Mr. STARK introduced the following bill; which was referred to the Committee on Ways and Means

---

A BILL

To amend title XVIII of the Social Security Act with respect to payment for capital-related costs for inpatient hospital services under the medicare program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Inpatient Hospital Capital Expenditures Amendments of 1989".

★

SEC. 2. REQUIRING STATE REVIEW MECHANISMS AS A CONDITION OF PAYMENT FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(h) LIMITATION ON PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES.—

"(1) AGREEMENT OR HIGH OCCUPANCY.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, during any fiscal year beginning on or after October 1, 1990, no payment shall be made under this title for capital-related costs (as defined in subsection (g)(1)(C)) of inpatient hospital services in a State unless—

"(i) the State has entered into an agreement with the Secretary to review capital expenditures for inpatient hospital services in accordance with paragraph (2), or

"(ii) has an average occupancy rate of greater than—

"(I) 85 percent for all licensed beds for hospitals in urban areas in the State, and

"(II) 75 percent for all licensed beds for hospitals in rural areas in the State,

during each of the 3 calendar years ending before the beginning of the fiscal year.

"(B) TERMS OF AGREEMENT.—Each agreement under this subsection may be terminated upon 90 days' notice—

"(i) by the Governor of a State, or

"(ii) by the Secretary if the Secretary determines that the State is not substantially complying with the agreement.

Instead of terminating such an agreement, the Secretary may extend an agreement, on a conditional basis, for a period of up to 12 months.

"(2) GENERAL CAPITAL REVIEW REQUIREMENTS.—In order for a State to meet the conditions of this paragraph, the Governor of the State must designate an agency of the State government (in this subsection referred to as the 'State review agency')—

"(A) to develop an Inpatient Hospital Facilities Plan (in this subsection referred to as an 'IHF Plan'), for the review of capital expenditures of inpatient hospital services in the State,

which meets the requirements of paragraph (4), and

"(B) to review such expenditures pursuant to such a review plan, in accordance with paragraph (5).

"(3) PERMITTING USE OF REGIONAL REVIEW AGENCIES.—A Governor also may designate a regional review agency (referred to in this paragraph as a 'regional review agency') to provide for review of capital expenditures of inpatient hospital services in all geographic regions in the State, but only if—

"(A) each such geographic region has a population of at least 500,000, and

"(B) each such agency—

"(i) is a nonprofit corporation or a public regional planning body or single unit of local government,

"(ii) is governed by a board a majority of the members of which are consumers or purchasers of health services in the region, and

"(iii) has resource allocation and planning in the region as its primary purpose.

"(4) INPATIENT HOSPITAL FACILITY (IHF) PLAN REQUIREMENTS.—

"(A) IN GENERAL.—Each IHF Plan must—

"(i) be developed consistent with criteria developed by the Secretary,

"(ii) designed to assure that the needs of the State's residents for inpatient hospital services are met,

"(iii) include occupancy targets for inpatient hospital facilities,

"(iv) be developed in consultation with appropriate mental health, mental retardation, alcoholism, and drug abuse authorities in the State, and

"(v) provide an opportunity for formal review and comment before becoming final.

"(B) SPECIFICS.—Each IHF Plan must—

"(i) assure access to hospital facilities,

"(ii) identify which hospital facilities (and parts of hospital facilities) would be closed in order to reach the occupancy targets for inpatient hospital facilities,

"(iii) provide for regionalization of inpatient hospital services, where appropriate, and

"(iv) address—

"(I) the special needs and circumstances of public and other disproportionate share hospitals (described in subsection (d)(5)(F)(i)),

"(II) the inpatient care needs of individuals with acquired immune deficiency syndrome (AIDS), and

"(III) the provision of trauma care.

"(5) REVIEW PLAN REQUIREMENTS.—

"(A) IN GENERAL.—Except as provided in paragraph (7), the review plan must—

"(i) provide for review of all proposed capital expenditures for inpatient hospital facilities in an urban area, if the aggregate proposed expenditures for a facility (or group of facilities) would exceed $1,000,000,

"(ii) consider the items described in subparagraph (B),

"(iii) meet the review requirements of subparagraph (C), and

"(iv) provide for such restraints as will assure that the capital-payment ratio limitation established under paragraph (6) is met.

The review plan may require review of, or notice with respect to, capital expenditures for a facility

which will not aggregate the amount specified in clause (i).

"(B) ITEMS TO BE CONSIDERED UNDER REVIEW PLAN.—The items to be considered under the review plan must include at least the following:

"(i) The relationship of the proposed capital expenditure to the IHF plan.

"(ii) The need that the population to be served has for the proposed services, equipment, or facility provided by the capital expenditure.

"(iii) The availability of alternative, less costly, or more effective methods for providing such services.

"(iv) The extent to which the proposed services, equipment, or facility will be available to all residents of the area, particularly those individuals without third-party health insurance coverage.

"(C) REVIEW REQUIREMENTS.—The review requirements under this subparagraph are as follows:

"(i) Reviews must be performed in accordance with procedures and criteria established in regulation.

"(ii) The determinations of the review must be made in public meetings.

"(iii) If local review agencies are established under paragraph (3), the State review agency must take the results of reviews by such agencies into account.

"(iv) The State review agency must make provision for access by the general public to all applications for review and for written findings of its reviews, which findings state the basis for agency determinations.

"(v) The State review agency must hold at least one public hearing if requested by persons directly affected by the review.

"(vi) Any decision of the State review agency to approve or not to approve a proposed capital expenditure must be based solely on the agency's review and the record created by the review.

"(vii) An application for a proposed capital expenditure must include a timetable for completing the project for which the expendi-

ture is proposed and any approval of such an expenditure shall be withdrawn if the State review agency finds that the applicant was not making a good faith effort to meet the timetable.

"(viii) The review plan must provide either for an appeals mechanism (consistent with the State's administrative procedures act) or for an appeal before an entity (other than the State review agency) designated by the Governor.

"(6) LIMITATIONS ON APPROVAL OF CAPITAL-RELATED ITEMS (OTHER THAN MOVEABLE EQUIPMENT).—

"(A) REQUIREMENT.—Each review plan must provide, in a manner satisfactory to the Secretary, for such controls as are necessary to assure that the fixed capital-payment ratio (as defined in subparagraph (D)) in the State in each fiscal year (beginning with fiscal year 1991) does not exceed the limiting fixed capital-payment ratio (as established under subparagraph (B)). In providing such assurances, the Secretary shall assist each State in determining, for the fiscal years involved—

"(i) the amounts that will be payable under part A for capital-related items (other than moveable equipment) for inpatient hospital services of subsection (d) hospitals in the State in the fiscal years, for items previously established or approved without regard to this subsection, and

"(ii) the amounts that will be payable under such part for operating costs of inpatient hospital services for such hospitals in the State in the fiscal years involved.

"(B) LIMITING FIXED CAPITAL-PAYMENT RATIO.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the limiting fixed capital-payment ratio for a State for a fiscal year is the fixed capital-payment ratio for the United States for fiscal year 1987, as estimated by the Secretary based on the best available data as of January 1, 1990.

"(ii) ADJUSTMENTS.—The Secretary, in consultation with the Prospective Payment Assessment Commission, may provide such adjustments to the limiting fixed capital-payment ratio applied to a State under clause (i)

as the Secretary determines to be appropriate (including taking into account unforeseen circumstances).

"(C) PERMITTING STATES WITH RURAL HEALTH PLAN TO LIMIT APPLICATION TO URBAN HOSPITALS.—In the case of a State that has developed a rural health plan that meets the requirements of paragraph (7), the State may elect, in a manner established by the Secretary, to have this paragraph applied, and the State's fixed capital-payment ratio determined, only with respect to capital-related items for hospitals located in an urban area (as determined for purposes of subsections (b) and (d)).

"(D) FIXED CAPITAL-PAYMENT RATIO DEFINED.—In this paragraph, the term 'fixed capital-payment ratio' means, for a State or the United States for a fiscal year, the ratio of—

"(i) the amounts payable under part A for capital-related items (other than moveable equipment) for inpatient hospital services of subsection (d) hospitals in the State or United States, respectively, in the fiscal year, to

"(ii) the amounts payable under such part for operating costs of inpatient hospital services for such hospitals in the State or the United States, respectively, in the fiscal year.

"(7) SPECIAL TREATMENT OF RURAL FACILITIES PERMITTED.—

"(A) IN GENERAL.—A review plan need not provide for review of inpatient hospital facilities in rural areas if the State has developed a rural health plan that meets the requirements of this paragraph.

"(B) REQUIREMENTS FOR RURAL HEALTH PLAN.—A rural health plan must—

"(i) meet criteria developed by the Secretary,

"(ii) have as its major focus the assurance of access to inpatient hospital services and other necessary health services by low density rural populations in the State, and

"(iii) address at least—

"(I) the regionalization of services,

"(II) alternatives to traditional inpatient hospital facilities,

"(III) the development of new organizational forms, and

"(IV) the needs for special emergency and other health-services-related transportation needs.

"(8) FUNDING ASSISTANCE TO STATES.—

"(A) IN GENERAL.—The Secretary shall make, in each fiscal year beginning with fiscal year 1990 from the allotment under subparagraph (B) for the State, a grant to each State with an agreement in effect under this subsection in an amount equal to 75 percent of the operating costs of carrying out the agreement under this subsection in the State in the fiscal year. Grants under this paragraph shall be payable from the Federal Hospital Insurance Trust Fund.

"(B) AMOUNT OF ALLOTMENT.—

"(i) IN GENERAL.—Subject to clauses (ii) and (iii), the amount of an allotment to each State is equal to the product of $0.70 and the population of the State.

"(ii) MINIMUM AND MAXIMUM ALLOTMENTS.—Subject to clause (iii)(II), in no case shall the allotment to a State be less

than $1,000,000 or be greater than $7,500,000.

"(iii) STATES WITH LOCAL REVIEW AGENCIES.—In the case of a State that has established local review agencies, the allotment to the State for each fiscal year—

"(I) subject to subclause (II), is equal to the product of $1.00 and the population of the State, but

"(II) shall not be less than $1,250,000, or greater than $10,000,000.

"(9) DEFINITIONS.—In this subsection:

"(A) The term 'Governor' means the chief executive officer of a State, or his designee.

"(B) The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

"(C) The term 'capital expenditure' means an expenditure which—

"(i)(I) under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, or (II) is made to obtain by lease or comparable

arrangement any facility thereof or any equipment for a facility or part, and

"(ii) which (I) exceeds $1,000,000, (II) changes the bed capacity of an inpatient hospital facility with respect to which the expenditure is made, or (III) substantially changes the inpatient hospital services provided.

For purposes of clause (i), the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plan and equipment with respect to which the expenditure is made shall be included in determining whether the expenditure exceeds the dollar amount specified in clause (i).

"(D) The terms 'urban area' and 'rural area' have the meanings given such terms in subsection (d)(2)(D).".

SEC. 3. PAYMENT ON A PROSPECTIVE BASIS FOR CAPITAL-RELATED COSTS FOR MOVEABLE EQUIPMENT FOR INPATIENT HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1886(g) of the Social Security Act (42 U.S.C. 1395ww(g)) is amended—

(1) in paragraph (1)(A), by inserting "(other than for moveable equipment, described in paragraph (4)(D))" after "capital-related costs";

(2) in paragraph (1)(C), by inserting "and paragraph (4)" after "In this paragraph"; and

(3) by adding at the end the following new paragraph:

"(4)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs for moveable equipment (as defined in subparagraph (D)), the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1990, provide for payments for such costs in accordance with a prospective payment system established by the Secretary.

"(B) Such system—

"(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

"(ii) shall provide for (I) initial payment rates to be based on a blend of a hospital-specific payment rate and a national payment rate, (II) such blend to phase out the portion attributable to the hospital-specific pay-

ment rate over a period of at least 3 fiscal years, (III) such rates to be based on the average per discharge reasonable costs for moveable equipment for capital-related costs of inpatient hospital services under this title for the most recent period, before October 1, 1988, for which adequate data area available, updated to the initial period through the use of appropriate national averages, and (IV) subsequent adjustments payment levels in the same manner as provided under subsection (d); and

"(iii) may provide for such exceptions as the Secretary determines to be appropriate.

"(C) In this paragraph, the term 'moveable equipment' means capital-related equipment that has the following characteristics, as the Secretary shall classify (and may from time to time modify) in a list:

"(i) A relatively fixed location in the building.

"(ii) Capability of being moved as distinguished from building equipment.

"(iii) A unit cost sufficient to justify ledger control.

"(iv) Sufficient size and identity to make control feasible by means of identification tags.

"(v) A minimum useful life of approximately 3 years.".

SEC. 4. EFFECTIVE DATE.

The amendments made by this Act shall take effect on October 1, 1990.

○

Chairman STARK. The Health Subcommittee of the Committee on Ways and Means will begin its hearing on fiscal year 1990 budget issues relating to reimbursement under the Medicare Program for hospital capital expenses.

Today, the committee will continue its consideration of issues relating to the 1990 budget and will be focusing on reimbursement under the Medicare Program for hospital capital.

No other issue relating to the hospital prospective payment system has the subcommittee devoted so much effort to for so little results.

Thus far, the only thing we have accomplished is to continue a flawed cost-based reimbursement system 5 years past its expiration date.

Unfortunately, the issue of capital reimbursement will not go away. Capital expenditures by hospitals appear to be out of control, or uncontrollable.

Over the last 5 years, with an increase in inflation of 17 percent, as measured by the GNP deflator, expenditures by Medicare to reimburse hospitals for their capital expenditures rose 76 percent.

If no action is taken, Medicare's aggregate payments to hospitals are estimated to rise at an average rate of 11 percent per year between 1989 and 1993. This will raise Medicare capital payments per case from $482 to $661, an increase of 37 percent.

These increases will occur while use of hospital facilities reaches ever higher levels of inefficiency. Average occupancy is now just over 64 percent for staff beds. That is down from 75 percent over the last decade. In other words, over one-third of the hospital beds in the Nation which are staffed—that means they have nurses and other staff standing by to use them—stand idle every day.

As we sit here today, there are 300,000 empty hospital beds, and staff members ready to serve them that are not being used. You are going to hear a lot of economic mumbo-jumbo today about how that is economically good for the system. I urge you to listen to that carefully.

Clearly, the status quo is not acceptable. One alternative is to support the position of the administration. The administration has proposed to pay hospital capital costs under Medicare at cost, minus 25 percent.

As I previously stated, absent any other alternative, I will support the 25-percent reduction. The capital cost explosion demands a strong response. I do believe there is a better way than, in effect, sequestering, and that would be to establish a system whereby each State, or each hospital, if you wish, is subject to a deliberate decision-making system about how much capital each hospital should incur.

It is obvious, if we reimburse hospitals for all the capital they want, the hospitals will not instigate that kind of a decision-making process. Why should they?

A limit must be established so that decisions would not result in mindless capital expenditures and such a system has to assure that needy hospitals will receive a level of capital reimbursement necessary for renovation, or expansion to be to the existing market, not expansion to go in and compete, and take markets away from other hospitals in the neighborhood who are already underutilized.

In response to those who would point out that capital review systems have not been as effective as we had hoped in the past, our bill provides the essential missing ingredient in those programs—an overall limit on capital expenses against which competing proposals can be evaluated.

Reimbursement of capital costs is one of the most important issues remaining in which the Congress has not reached consensus regarding Medicare payment policies.

I believe that the bill I have introduced represents an effort to provide a new approach that takes some of the old and the new in order to provide a reasonable and orderly response to the need for a hospital capital investment policy.

I look forward to the comments of the witnesses and the inquiry of our members on these issues.

Chairman STARK. Are there other opening statements?

[No response.]

Chairman STARK. Our first witness will be Bruce Vladeck, the president of the United Hospital Fund of New York, a gentlemen who has worked with this committee on many occasions. Welcome back to the committee. Bruce, without objection, your prepared testimony will appear in the record in its entirety, and you may enlighten us in any manner, that you feel comfortable with. Please proceed.

STATEMENT OF BRUCE C. VLADECK, PRESIDENT, UNITED HOSPITAL FUND OF NEW YORK

Mr. VLADECK. Thank you very much, Mr. Chairman, members of the committee. I will try to do whatever I do quite briefly.

As you know, I am president of the United Hospital Fund of New York and a member of the Prospective Payment Assessment Commission, but I must begin by stating that in terms of my remarks this afternoon I am formally representing neither.

Nonetheless, it is a special honor and privilege to have this opportunity to talk to you about capital issues today.

I do not think I have to tell any of you how difficult and how complicated, or how emotionally charged, the issue of capital reimbursement policy can be. Not only has it bedeviled us since the enactment of PPS, but in fact it has been a subject of considerable contention and unhappiness since the time Medicare was enacted, 24 years ago.

I do believe that over the last several years we have reached a kind of intellectual stalemate around the issues of capital reimbursement. As you know, I am one of those who unlike you, Mr. Chairman, has applauded the rejection by the Congress of the flat add-on to per case rates for inclusion of capital, at least for basic plant.

On the other hand, I think the policy embodied in current law, not to mention the administration's budget proposal, represents less a defense of the status quo than the unavailability of any other options, and therefore while—as you will see—I disagree in a number of respects with H.R. 712, I do want to congratulate you on this effort to move the debate off the dime, to end this stalemate we have had around capital policy, really, since the debates leading

to the enactment of PPS, and to begin to think about some new ideas.

In response to that issue, what I would like to do, very briefly, is just touch on a few issues I think we need to address as part of any capital policy, and make a few observations about the issue of State regulation of capital expenditures by health care facilities.

And then, if I could offer a few comments specifically on H.R. 712 and some of the concepts it contains.

First, in terms of the complexities and difficulties surrounding this issue, I think it is important to recognize that while capital reimbursement is a very important part of the payment system, it does not stand entirely alone, and at the same time, there are very considerable lags in the capital investment process.

I think what we are seeing in terms of Medicare capital costs in fiscal years 1988, 1987, 1986, represent investment decisions largely made by hospitals in 1982, 1983, 1984, when they may have been motivated as much by the anticipation of changes in tax policy, more than changes in Medicare reimbursement.

At the same time I suspect that even though we continue to have overgenerous incentives for at least some hospitals to invest in capital, under the current system they are not insensitive either to conditions in financial markets or to the perception of financial markets that overall hospital margins have dwindled, and hospitals are therefore a less good risk for various loan purposes.

So what actually occurs in terms of Medicare costs is compounded of a number of different pieces. The other thing that is very important, and that, frankly, I think defeated the notion of the flat add-on, has to do with the extremely long life cycle of capital projects.

If nothing else, the typical life of a 30-year financing, given how rapidly we change policy in other areas, makes discussions of some of these issues awfully confusing and intellectually difficult to keep track of.

But I think it is important to recognize that because of the difference in institutional life cycles, you cannot say, a priori, that a hospital with capitals cost of x dollars per bed, adjusted for case mix, adjusted for wages—all of those things—is necessarily either more or less efficient in its use of capital than a hospital with adjusted Medicare-defined costs of half of that, or two times x, unless you know where the institution is in the life cycle, and therefore, developing any uniform policy—as you know—raises all kinds of problems.

Similarly, we have an industry that is seriously overcapitalized in the aggregate but undercapitalized in some important ways. Clearly, many of our public institutions, especially in inner cities, are undercapitalized and have difficulty getting access to capital.

Some rural community institutions are undercapitalized, and in both your part of the world, Mr. Chairman, and mine, there is a terrible shortage of capital for development of both acute and long-term care facilities for people infected with the HIV virus, when we can project how many facilities we are going to need 5 years from now, 10 years from now, and are not building them, in part because we cannot find the capital.

Given time pressures and given the fact that my colleague, Dr. Kimmey, who probably knows more about the issue than anyone else, is also testifying today, I will not say very much about the experience in health planning except to say I think that if you realize that there are a lot of equities to be considered, a lot of interests to be balanced, a lot of institutions which serve important needs in the context of general overcapitalization, and at the same time a need for some kind of budgetary constraint, you need some process to rationalize decisionmaking, and I do not know what will work better than some sort of planning mechanism.

I think the experience has been highly variable from State-to-State and place-to-place, and from time-to-time, and I think what we need to do in public policy is find a mechanism that accommodates those States that are capable of and interested in doing the job, while providing other States with an appropriate incentive to adopt such systems and yet not being unduly punitive of institutions in those States, when for whatever reason the political climate is going to militate against effective planning processes.

Having said that, let me just close with a few comments if I could. I think you are quite right, in principle, that if we want planning to work we need an aggregate limit on expenditures, probably at the State level.

I do not think you can effectively mandate the States to develop capital planning programs. I think you need some other mechanism for capital payment to enforce a limit in States that do not have planning and certificate of need, perhaps a pro rata reduction in reimbursements to institutions in those States, in essence a federally administered cap, as it were.

I very much support the notion of incorporating costs associated with equipment into the Prospective Payment System. I think we should go further than many of the proposals around and do that on a DRG-specific basis which gets the economic and clinical incentives right, and which is not very difficult to do.

I also think that we should recognize that whatever we do in terms of aggregate capital expenditures we are going to have certain classes of facilities or certain kinds of problems for whom even generous Medicare reimbursement is not going to be adequate.

And I think that even in this period of budget constraint and unhappiness about general policies towards things such as loan guarantees or credit subsidies—in fact there is a long and effective history of such mechanisms in health care in this country.

If we are going to get capital where it is needed, it is not going to be enough to fiddle with Medicare reimbursement. We are going to have to address some other forms of capital assistance to rural institutions, to certain inner-city institutions, for special services like those for persons with AIDS.

There is a lot more I could say, Mr. Chairman. I want to observe your interest in terms of time.

I appreciate your having entered my statement into the record. I am happy to take any questions you might have. I would just say by way of summary, that I think we do have to move away from the stalemate. I think we do need a mechanism for capping Medicare's liability.

If you want to allocate some fixed pool in a reasonably fair and equitable way, however, you cannot trust on some magic formula to do it. You need an administrative or policymaking process to do it.

Some States have shown the capability to do that and they should be encouraged, I believe, by the Federal Government to continue to do so.

I appreciate the opportunity to be here, and I am happy to answer any questions that you have.

[The statement of Mr. Vladeck follows:]

Statement of Bruce C. Vladeck, United Hospital Fund of New York

Mr. Chairman, members of the Committee, my name is Bruce C. Vladeck. I am President of the United Hospital Fund of New York, a philanthropic and research organization; as you know, I am also a member of the Prospective Payment Assessment Commission. I appear before you today representing neither of those organizations, but rather as someone who has been engaged in the design and implementation of hospital payment systems for more than a decade. It is a special honor and privilege to have the opportunity to do so.

I don't have to tell any of you that the problem of how to most appropriately pay hospitals for the costs associated with capital expenditures has bedevilled policymakers since the inception of debate surrounding the enactment of the Prospective Payment System (PPS) in 1983. Indeed, the problem of hospital capital expenditures, and how to provide the appropriate incentives and disincentives in the reimbursement process, has been of concern since very shortly after the enactment of Medicare in 1965.

I don't think anyone would question the general proposition that, in the aggregate, the hospital sector is overcapitalized. That is, as a society we have far more hospital beds than we need, as evidenced by occupancy percentages that hover in the low 60s, and by the expense of maintaining that excess capacity. More precisely, we have far more hospital beds than we seem prepared to make effective use of; other industrial countries actually have more beds, in proportion to population, than we do, but are more rational in using them effectively for chronic care patients of the kind we have progressively excluded from hospitals in a self-defeating search for cost containment. At the same time, however, parts of our hospital sector are probably undercapitalized, notably including public and voluntary hospitals in many inner-city communities.

Similarly, I think the evidence is clear that, at least under certain circumstances, excessive capital investment leads to adverse qualitative outcomes for patients, as appears to be the case in the example of cardiac surgical services in metropolitan Phoenix. Overinvestment can also increase expense when too many facilities in a given market chase too few patients, as the work of Luft and Robinson has demonstrated. On the other hand, undercapitalized urban and rural hospitals unable to maintain the most modern and effective equipment probably can not provide either clinically or economically optimal care to their patients.

More generally, decisions about capital reimbursement policy inevitably embody decisions about what kind of health care system we want to have. To the extent that we want both to minimize Medicare expenditures and maximize geographic accessibility and physician independence, rationalize the development of new technologies but insure their rapid diffusion to every Medicare beneficiary, encourage more economically rational behavior on the part of fundamentally uneconomic institutions, and simultaneously promote both greater efficiency and greater equity, we are going to have some difficult problems. And we tend to load all those objectives - or aspirations - on to the back of capital reimbursement policy.

Thus, it is perhaps not so surprising that over the last several years we seem to have reached a sort of intellectual stalemate around the issue of capital reimbursement. On more than one occasion, the Congress has decisively rejected proposals to treat capital expenses through the addition of a flat, arbitrary prospective amount to each per-case payment, a rejection I personally

applaud. The policy embodied both in current law and in the administration's budget proposals, however, reflects, I would suggest, less a defense of the status quo than the absence of any more palatable alternatives. In that regard, Mr. Chairman, I wish to particularly congratulate you for your proposal of H.R. 712, the Medicare Inpatient Hospital Capital Expenditure Amendments of 1989. While, as I will discuss later, I do not agree with everything contained in that bill, it represents an important effort to move the discussion of capital reimbursement off the dime, and to begin to consider innovative approaches to the problems posed by capital payment policy.

In seeking to be responsive to your hearing call as well as to the specifics of H.R. 712, Mr. Chairman, I propose to do the following. First, I want to describe some of the complexities I perceive to surround the issues of capital reimbursement that must be dealt with in the design of better policy. In doing so, I will try to address some general issues, such as the relationship of capital reimbursement to the rest of PPS. Then I would like to comment specifically on the issue of state regulation of capital expenditures, which plays so central a part in your bill, and which has so long been so controversial. Then I will comment specifically on H.R. 712, and make some alternative suggestions of my own.

Dimensions of the Issue

In addition to the more general considerations I enumerated above, capital reimbursement policy is complex because of the relationship between capital and operating costs, which is itself complex and not always well-understood; because the effects of reimbursement policy are very much conditioned on changes in capital markets and tax policy; because there are some very severe problems of timing and information; and, not least, because what is optimal from a narrow point of view of economic efficiency may not be congruent with sound public policy - as, for example, in the case of inner city or rural sole community providers survival of which is essential for insuring access to needed services by Medicare beneficiaries, but which on their own are incapable of competing effectively in capital markets. What is clear, as you have emphasized in your opening statement, Mr. Chairman, is that capital remains the single uncontrolled element in the PPS payment system. As such, it already comprises a growing share of total Medicare hospital payments, a fraction that can only be expected to increase in the coming years. Further, under the rules of the Gramm-Rudman budgetary game, that means that capital expenditures will increasingly preclude expenditures on other, possibly more worthwhile or more necessary activities.

On the other hand - to touch on one degree of complexity - I suspect that Medicare capital costs have increased so rapidly in the last two or three years at least in part because of the behavior of hospitals in 1983, '84, and '85 which was undertaken in anticipation both of changes in Medicare payment policy and of changes in the tax law which might restrict access to tax-exempt debt. In the typical major hospital capital project, the expenses associated with the financing of new construction do not appear on cost reports until after a new facility is on line, which typically occurs anywhere from two to five years after the money to pay for that facility has been borrowed. One can not be reimbursed for the costs of a physical asset that does not yet exist. On the other hand, in future years we will see the impact on capital spending of current economic conditions in the hospital industry, in which margins have shrunk considerably, positive financial feasibility studies are much harder to come by, and the marketplace views hospital debt with considerably more skepticism than it did in the recent past. In short, in implementing any new capital payment policy, one is not only shooting at a moving target, but shooting at a moving target in the dark.

More generally, however generous capital reimbursement policy may be, its effects can not be projected entirely in isolation from the overall economic condition of hospitals, which is itself related to reimbursement for non-capital expenses. When operating cost reimbursement is very generous, hospitals may be able to contribute substantial operating surpluses to capital projects, thus reducing their need to borrow and diluting the impact of capital reimbursement incentives. Conversely, when hospitals experience serious operating difficulties, reimbursement originally targeted for capital maintenance and replacement may well be deployed to provide operating cash; reimbursement dollars are, after all, fungible.

This phenomenon also affects how theoretical reimbursement incentives actually affect hospital behavior. It is clear that, all other things being equal, traditional cost-based reimbursement of capital expenses provided hospitals with considerable incentive to overinvest in plant and equipment, and to borrow money rather than to save. Further, when operating revenues are constrained, as they are under PPS, while capital reimbursement is open-ended, there are obvious incentives for hospitals to substitute uncontrolled capital for constrained labor and other inputs. On the other hand, the incentives of operating-cost reimbursement under PPS encourage hospitals to minimize fixed costs of all kinds while seeking to use assets as intensively as possible. In an industry with significant overcapacity and small operating margins, these considerations, involving 92% of hospitals' total costs, may well outweigh capital incentives affecting the other 8%.

The final general consideration I would mention here is that of the very long lifecycles involved in capital projects. There is enormous variation in capital costs per discharge or per bed across hospitals, but those differences are far more a result of hospitals being at different stages in the lifecycle of their physical plants than anything else. As you will recall from the discussion of transition periods for a capital add-on, that means that any relatively rigid formula for payment of capital costs runs the risks of severe inequities, not only significantly underpaying facilities that have just completed modernization activities, but also overpaying those at later points in the lifecycle of their assets. As has been the case with the movement to national rates under PPS generally, that means that application of a simple formula requires significantly overpaying many institutions if you are not going to do serious harm to others. More importantly, however, there is no particular reason to believe that there is any relationship between where a particular hospital is in its replacement cycle and the extent to which that hospital is really needed by the community it serves. It is impossible to conclude anything either about the relative efficiency of a hospital's use of capital or about the extent to which the capital invested in that institution is socially productive just by looking at a hospital's relative capital costs.

The Experience of Health Planning

The logical way to deal with this sort of variability, of course, as well as with the obligation to be responsive to community need along with budgetary pressures, is to maintain some sort of formal planning process, as H.R. 712 certainly recognizes. To even talk about "health planning" is, however, to raise a whole series of red flags, about which I would like to offer a few comments.

The literature on the effectiveness of the federal health planning program in controlling the growth of hospital capital expenses is certainly mixed. The preponderance of the literature argues that the process wasn't very effective at all, but much of the argument in that regard has a significant ideological tinge, rooted in the assumption that health planning can't work by definition because it constitutes governmental interference in the marketplace. Although we will never achieve general consensus on these issues, I do think it is possible

nonetheless to draw several general conclusions from the experience to date with capital facilities regulation through a health planning process.

- First, health planning and certificate of need certainly worked substantially better in some jurisdictions than in others. Analysts have attributed these differences to differences in "political will" from one state to another. My own view is that, for reasons of history, political culture, and political structure, some states simply provide more receptive soil for this tender reed than do others, and I'm not at all sure that there's very much the federal government can do to insure more uniformity in state response.

- An attempt to impose rigid national standards was only one of the many shortcomings of the federal government's administration of the National Health Planning and Resources Development Act of 1974 and its subsequent amendments. I admit to a certain degree of bias on this subject, having administered a State Health Planning and Development Agency for several years, and, given the competition, it would certainly be hyperbolic to say that the health planning program was one of the worst-administered federal programs in recent memory. But it is worth noting that, through most of its history, that law was administered by executive branch officials fundamentally hostile to its purposes, and was never supported at anywhere near its authorized budget levels.

- In terms of controlling capital expenditures, I do think the record is clear that, at least in some states, health planning has made a difference; that, for a variety of reasons, it has been substantially more effective at deterring the development of new capacity than at controlling the costs of modernization and replacement (admittedly the object of most major hospital capital expenditures in the last decade or so); and that it has worked substantially better in controlling the growth of nursing homes than in controlling the growth of the hospital sector, presumably because states have had a far greater financial stake in nursing home capacity, where Medicaid is the overwhelmingly predominant payer, than in hospitals, where Medicaid's share is generally much smaller. Further, I do think the record shows that, in those states that have had the political will, wherever it came from, the certificate of need process has helped tilt the capital investment process in the direction of inner city, disproportionate share, rural, and other socially desirable institutions.

- As the previous point suggests, I think there is also a high degree of consensus that the certificate of need process would work substantially better if it were subject to some degree of aggregate economic constraint. As was noted a number of years ago, the benefits of new capital investment in health care are enjoyed locally, while the costs are diffused over a broad area - indeed, to a considerable extent, to the federal treasury - so that the political calculus for local planning agencies and state governments was fundamentally distorted. If the experience of PPS has taught us nothing else, it has certainly brought home the lesson that the politics of "zero-sum" allocation of a fixed pie are radically different from those in which there is no aggregate budgetary limit.

- Finally, as a New Yorker I am constrained to add that while, in most of the country, the certificate-of-need process did not work nearly well enough, in my native state it may have worked too well. Certainly, our experience in New York in the last two or three years has taught us that a regulatory apparatus designed to shrink the system can't be very readily turned around to expand or redeploy it when needs change. How much of the failure of New York's health planning apparatus to respond to the current crisis in utilization we are experiencing is inherent in the regulatory process, however, as opposed to being a result of some of the peculiarities of our own bureaucratic system or simply a screen for state budgetary decisions, I really can't say.

In summary, I think it can fairly be argued that certificate-of-need probably can work to allocate finite capital resources in some states, though probably never in all. If the amount of capital made available in the reimbursement system is to be substantially less than might otherwise be invested by hospitals or other health providers, I further believe, it is probably more equitable and better public policy to allocate it by some rational mechanism ultimately accountable to the broader public than by chance or circumstance. I will comment in a moment on the implications of that for Medicare payment policy.

Towards A Better Capital Reimbursement Policy

Thus, I begin my specific comments on H.R. 712 by agreeing strongly with two fundamental precepts of that bill: first, that so long as cost-based reimbursement for capital expenses is to be continued, it is necessary to place some sort of aggregate limit on those expenses, which is probably best done on a state-by-state basis. Those limits are probably best implemented through a state planning process, which the federal government, as a major beneficiary of effective planning, should support financially.

I also strongly applaud the provision in H.R. 712 that would incorporate payments for major medical equipment (MME) into per-case rates. Indeed, I know of no one who has seriously considered this issue who would oppose such an approach. I would, however, go further. Equipment costs per case vary considerably from one DRG to the next, as well they should for clinical reasons. If we want to try to get the right economic incentives into per-case prices, as well as assuring payment equity across DRGs in order to insure neutrality of clinical incentives, then reimbursement for MME costs should be DRG-specific. From a technical point of view, incorporating MME into specific DRG weights can be done relatively straightforwardly as part of the recalibration process. Indeed, we were reimbursing MME on a DRG-specific basis in New Jersey nine years ago.

On the other hand, I think it is simply unrealistic to expect every state to effectively administer a planning program, and thus especially punitive to hospitals to withhold all capital reimbursement in states that fail to operate such programs. Permit me to suggest, as an alternative, that in states without planning programs, a *cap* be maintained on Medicare capital payments, enforced by pro rata reductions in all such payments when cost-based reimbursement would otherwise exceed the cap. Such a policy, I would suggest, would provide the hospital community in laggard states with a powerful incentive to support the development of health planning programs, or to develop alternatives which might function better in particular political contexts.

More importantly, I agree with the premise of H.R. 712 that statewide occupancy rates are a reasonable surrogate measure of the extent of excess of under-capacity in a given state, and that federal policy should be sensitive to interstate differences in capital investment relative to utilization or need. But I believe the logic of that criterion should be extended further. If hospital capital is utilized more efficiently in some states than in others, which is true by definition if occupancy rates are a reasonable surrogate measure of the relationship between capacity and utilization, then a statewide capital payment cap established through a uniform national formula would have a punitive effect on the most efficient states, while still overpaying those that were most overcapitalized. Instead, I would propose a different approach, based on the following logic.

Assume a normative aggregate annual hospital occupancy rate of 80% in urban areas and 70% in rural areas. Assume further a target rate of increase in total PPS capital expenses equal to the annual increase in the PPS update

factor plus the annual increase in the aggregate PPS case-mix index. (As ProPAC has demonstrated, increases in average case-mix complexity have contributed more to increases in hospital payments under PPS than have the update factors, and such case-mix increases are now routinely "discounted" in the establishment of the update factor.) Then, a state with an occupancy rate exactly equal to the national standard should receive exactly that average rate of increase in hospital capital payments. States with higher occupancy rates should receive more than the average increase, while those with lower rates should receive less. A reasonable formula would be to multiply the target rate of increase by the state's actual occupancy rate (weighted for urban and rural components) divided by the national standard (also weighted for the urban-rural proportions). To give an example, a state with all urban hospitals and 90% occupancy would receive 112.5% of the national rate of increase, while a similar state with a 70% rate would receive 87.25% of the national rate of increase.

The major problem with that approach is the very considerable one of time lags, since a major capital expenditure approved tomorrow will not create reimbursable costs until 1992 or '93 at the earliest, and I don't believe anyone can project what the increase in the market basket, let alone in total PPS payments, will or should be between now and then. I suspect the answer there is to impose constraints not on total payments, per se, but on total approvals, in those states which maintain planning programs, or total projects undertaken, in those states that do not. There is no reason that Medicare could not adopt a policy that it will never recognize capital costs of a project the costs of which were not reported to the fiscal intermediary when the project was undertaken, and in states without approval processes, the intermediaries would have plenty of lead time in which to impose pro rate reductions on payments when new starts exceeded the cap.

Imposing a cap on project approvals or starts also renders the system fully and truly prospective. Otherwise, whenever a new system is implemented, some institutions may find themselves with obligations, entered into in good faith, which they are unable to meet - thus generating pressures for transition periods, exceptions policies, or whatever. Tying the cap to prospective projects creates a built-in transition period.

Nonetheless, in designing such a policy, it is probably wise to allow for categorical exceptions as well. One would not want to force states to trade off AIDS facilities against needed public hospital modernization, for example, nor would one wish approval of a single very large project to unnecessarily delay worthwhile smaller ones. A well-defined and carefully formulated exceptions process could be a powerful public policy instrument to direct capital investment in desired directions.

I believe, Mr. Chairman, that your proposal of statewide capital expenditure caps, as modified by my suggestions, could effectively impose some real constraints on the growth of Medicare capital payments, but do so in an equitable and fair way. Two other problems would still remain, however.

First, even under perfectly equitable cost-based reimbursement, many institutions serving a vital community purpose consistent with everyone's public policy objectives would still have difficulty gaining access to capital markets. I refer specifically, of course, to high disproportionate share hospitals, needed sole community rural hospitals, and providers of special services, such as those for AIDS patients. Such institutions will be unable to borrow money in the conventional credit markets no matter how well they would be reimbursed for borrowed funds if they could get them. Hence, I would urge you to consider, as part of any strategy for dealing with the capital issue, additional measures to assist such facilities. Specifically, I think it would be appropriate to

consider loan guarantees, other credit enhancements, or even direct Trust Fund subsidies to certain categories of institutions which will not otherwise be able to raise the necessary funds to provide access to high quality services for the Medicare beneficiaries they care for.

On an unrelated, but similarly important issue, another valid criticism of state certificate-of-need regulation has been its general inability to control the acquisition of expensive equipment outside institutional walls. That has perhaps further encouraged the "unbundling" of a whole range of high-technology diagnostic and treatment services, for which the economic incentives to unbundle would probably have been sufficiently powerful in any case. In a sense, this is a classic Part A/Part B issue, but we do ourselves a serious disservice if we exercise more effective control of in-institution technology while continuing to encourage the excessive, wasteful, and expensive dissemination of such technologies in a variety of freestanding sites and physicians' offices. I know you will be devoting a lot of time this year to issues of physician payment and of Part B more generally, and I would urge you to keep the capital component of those issues very much in mind as you consider alternative policy approaches. There is no question in my mind that, in the aggregate, the "creaming" inherent in such unbundling increases average hospital costs as well as total Medicare costs, and thus any complete consideration of hospital capital reimbursement policy must address this issue.

Conclusions

I would not claim, Mr. Chairman, that either H.R. 712 or my suggested modifications to it necessarily provide all the answers to the longstanding thorny dilemmas of hospital capital payment policy. I do believe, on the other hand, that they are much preferable to either the status quo or any other suggestions I have seen advanced recently. As such, I am hopeful that they may permit us to refocus our debate and deliberation on these issues, and to begin to move towards better public policy.

In such deliberation, I think we need to keep just a few basic principles in mind. First, and most obviously, we need to get control of capital costs - in order to permit us, in an era of fiscal constraints, to do better things with the money that would otherwise further expand an already overcapitalized industry. Second, while controlling costs, we need to remain sensitive to the extraordinary diversity from one part of this country to another of the hospital community and the political environment in which hospitals reside, not to mention the significant differences among hospitals in the same communities. While the industry as a whole may be overcapitalized, parts remain undercapitalized, and we must somehow account for that as well. That all necessitates, it seems to me, a policy that is more complex, more flexible, and more situational, less intellectually pure and elegant, than one might otherwise prefer. But I don't know that we have any reasonable alternative.

I'm very grateful for the opportunity to share these views with you today, and I would of course be happy to respond to any questions you might have.

Chairman STARK. Can you make some clear distinctions between States which have had either certificate of need, or capital allocation, or highly regulated hospital systems? I do not think there are any that still continue that, are there? Are there any States that still have a very strict control system?

Mr. VLADECK. Well, what you mean by "strict" is debatable. I have seen both the number of 31 and 38 States that, at the moment, still maintain a certificate of need program.

Chairman STARK. Can you draw any conclusions from those as to who has lower overall hospital costs? I often use California and New York but that is——

Mr. VLADECK. The only thing I can comment about, having looked at in detail—and again, Dr. Kimmey knows more about this than I do—is that States in the Northeastern part of the country, which began in the early 1970's, with costs, by most measures, substantially higher than the rest of the country, now those States with the most extensive regulatory programs are generally in the bottom third or bottom quarter of costs on a number of measures, and one would think that might have something to do with the policies they have implemented over the last decade or so.

Chairman STARK. Are you generally familiar with hospital operations?

Mr. VLADECK. In a general sense, certainly.

Chairman STARK. Because one of the things that we are going to hear today is that empty staffed beds have little or no impact on costs. As a matter of fact I bet we will hear before the end of the day that they even lower costs, but I have not read the testimony. I am sure that will come out.

Let's take pieces of that. I am only vaguely familiar with the restaurant business, but it seems to me that we have, in this restaurant I am familiar with, 100 and some-odd seats.

If we think that on a Wednesday night we are going to have 50 customers, then we have got enough waiters and cooks, and busboys, and people standing by to serve 50 meals.

And I might add, we have got enough food in the refrigerator to give to these 50 people that we anticipate coming, and we are paying the salaries of all those folks standing by.

Now isn't that somewhat analogous to—if we are expecting 50 diners—if you have 50 staffed beds in a hospital, you have got food for the folks in the refrigerator, and you have got nurses, or LVNs, or orderlies ready to deliver the trays. Is that a logical conclusion for me to——

Mr. VLADECK. Well, I think there are a couple of considerations, Mr. Chairman. The first is, we do expect of hospitals in most of the country that—to extend your analogy for a minute. If somebody gets hungry at 3:30 in the morning, they can get whatever they want to eat.

So we do pay a significant cost for community standby capacity that I think is——

Chairman STARK. OK. What I am getting at is, if I only get 20 people to show up that night, I really lose a lot of money. And it is beyond me to quite figure out how, if I do not run a little fuller each night—now just the food side of this—that I do not save

money because I can plan more accurately, I have less waste, I do not have waiters standing around doing nothing.

And the union will not let them do anything else. I mean, I cannot have them wash the windows while they are waiting. I just have a little trouble understanding how, when you have hospitals, as I do in my State, that are pressing to be 60-percent utilized, how that does not impact cost. Help me.

Mr. VLADECK. Well, I suspect they are not all fully staffed and many of them use——

Chairman STARK. I mean, if that is a definition that is acceptable, means the same in each State, we are constantly talking staffed beds, not rooms without people around to attend to them.

Mr. VLADECK. I think the real expense is when there are two such places across the street from each other that are both half full, and if you look at all of the studies that have been done on marginal costs in hospitals—in fact hospitals are very high fixed-cost operations, in practice. In theory, they might be less so, but they do not hire laboratory technicians on a totally variable basis, for example.

The great inefficiency, economically, comes not I think from too many empty beds per se but too many half-full institutions, and that the savings over a period of time are to be achieved less by shrinking existing institutions than by consolidation.

We probably do not, as a Nation, need 6,000 hospital administrators, to start with one category of expenses that will get me in trouble.

Chairman STARK. Boy, I would join that campaign.

Mr. VLADECK. But given a high fixed-cost base, it is the number of facilities you have more I think than—and occupancy rates are an indicator that you probably have more facilities than you need—is a more expensive phenomenon than having facilities at less than optimal capacity.

Chairman STARK. Thank you. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman, and thank you for your comments. As a newcomer to the details of this debate, but coming from a State where hospital costs are highly regulated and have been for some time, I am also familiar with the difficulties of regulation and the challenge that they pose for us.

In your comments you mentioned that you cannot take capital cost as a measure of efficiency without knowing a lot about the institution itself.

What I see happening in my institutions is a lot less of their capital money going to bricks and mortar, expansion, rehabilitation, renovation, building, and a lot more going to equipment.

In fact more than 50 percent, on average, in Connecticut goes to equipment. I mean, theoretically, if you are going to cap the amount of capital any State has, and you are going to try to allocate it over equipment and mortar, there may be hospitals that will not be able to buy equipment that they consider important.

How would you protect institutions from suits brought because state-of-the-art tests were not done because there was no equipment, and is that an issue that is in any setting beginning to raise its head?

It is an issue that developed in Canada at one point, which is also a capped-cost system. But with their very different tradition of litigation and different laws, different legal structure, it did not become a liability issue.

I am concerned about the implications of making access to equipment impossible for certain hospitals in today's litigious environment.

Mr. VLADECK. Let me say two things, if I might. The first is that think we ought to treat equipment separately under PPS. I think since the typical piece of diagnostic or therapeutic equipment has an effective life of 5 to 7 years, maybe 10 in the case of some x ray equipment, you do not have the kind of extreme life-cycle problems you have with plant.

You also have a much more rapidly changing technology, clearly, and you do have the question of incentives to use equipment as opposed to labor effectively.

So I am all for incorporating equipment costs into DRG rates, and it has been done in New Jersey since 1980. It has been done in Maryland since the early 1980's. It is not technically hard to do, and I think it makes a fair amount of sense.

At the same time you do that, however, since you have jurisdiction, if I may say, that most State governments do not have in this regard, I think you have to address the unbundling phenomenon at the same time.

What has hurt us economically in terms of equipment acquisition over the last 5 or 8 years has not been the hospitals, even though they have been essentially unconstrained.

From a capital point of view, it has been the proliferation of increasingly fancy and sophisticated technology in physicians' offices and in freestanding centers of one sort or another.

When you do that, you are almost certain to substantially increase your costs, first, because the hospital, because of its residual community standby capacity, continues to have to have the equipment as well. Most of this stuff operates at some point below capacity.

And because of the way in which we finance most of this out-of-hospital equipment requires basically very high prices in order to make those investments sound.

So I think if we are going to say to hospitals that they have to have some economic constraint in terms of the purchase of equipment, which I think is appropriate, I think that needs to be conditioned on a level playing field in which their own attending staff cannot take the business to their own partially owned MRI, or a multi-channel lab, or whatever, across the street.

Mrs. JOHNSON. Could I just interrupt you a minute.

It is my understanding that capital reimbursements do currently cover equipment costs, correct?

Mr. VLADECK. That is correct.

Mrs. JOHNSON. And that we currently have no constraint on private-sector investment in capital equipment?

Mr. VLADECK. That is correct.

Mrs. JOHNSON. I can see that Government might have the right to constrain the development of facilities owned by physicians, but

I do not see that we would have any way of controlling private-sector investment in medical capital equipment.

Mr. VLADECK. Well, I think you have complete jurisdiction over what part B pays for an out-of-hospital CAT scan, or an out-of-hospital MRI, or out-of-hospital endoscopy, or things of that sort.

And I think the literature is increasingly of the view that the payment system under part B, as well as under private insurance, encourages the proliferation of that kind of out-of-institution technology.

So that as you begin to look at the part B payment system, I would hope that is one of the issues that would be part of the calculus in figuring that system out.

Mrs. JOHNSON. Thank you. That is very helpful. Thank you, Mr. Chairman.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Vladeck, I found your testimony interesting. I think we all have to agree that low occupancy is a serious problem for us.

I do not find in your statement, though, a lot of explanation to account for why this is happening. Why do we have these low occupancy rates? And rather than trying to address just the occupancy rate primarily, I think it is more important for us to find out why occupancy is low.

Now I think in my own State, we have low occupancy in some areas, and I have to ask myself over and over why that is. That is what I am going to be looking for, rather than just automatically taking a measurement of low occupancy and improving a capital limitation.

I think we probably built more hospitals under the Hill-Burton than we needed, but 30–40 years ago the Congress insisted we do that. That clock is popping a little bit quick on me here today.

Chairman STARK. No, that must be——

Mr. PICKLE. It has not gotten warmed up yet. But Hill-Burton encouraged us to build a lot of hospitals. Now some are not being occupied because larger new hospitals are built in urban areas, and a lot of patients are going in there, and we are having to close some hospitals down which I think is a result of low occupancy.

Now what is the answer? I am not sure. Are you saying we ought to do away with the certificate of need?

Mr. VLADECK. No, sir. I am saying that we ought to put some degree of limit on Medicare's liability for capital expenditures.

Mr. PICKLE. All right. Yes, I got that.

Mr. VLADECK. I think some States are going to want to administer that limit through a certificate of need process, and more power to them.

Mr. PICKLE. All right. But you said in some instances certificate of need would work and in other States it might not work at all. Now how are we going to take care of those States where it does not work?

Mr. VLADECK. Well, I think there is a question of what the Federal Government ought to do to encourage the hospital community in those States that do not have certificate of need to do something.

It seems to me if you said the cap for State—I want to pick an appropriate and neutral State here—the State of New Jersey was

$100 million, and they did not have a certificate-of-need program, then you would tell the fiscal intermediary in essence to look at the cost reports, and to pay reimbursable capital costs up to $100 million, and if it came to 110 to reduce it pro rata.

I think after a while the hospitals in that State would come up with some other mechanism.

Mr. PICKLE. Well, I am looking for some kind of approach that helps on this problem but not limit capital payments strictly based on the rate of occupancy. Coming from a State with many hospitals with low occupancy, I find that hard to accept, just as the sole or the primary approach.

In Medicare policy we are encouraging hospitals to get people out of the hospital quick, by the same token you would have us say we are just going to restrict your capital payments, we are going to penalize you because you have low occupancy .

I think we have got to weigh a lot of other factors. It seems to me that if we were to take your approach, we really would close down most rural hospitals in this country. Now that might not be your intent, but if you were going to use occupancy as a measurement, the rural hospitals are pretty well caught because they have been left to take care of people that the urban will not.

And there is a particular need, just as you said, for the sole-source hospital or disproportionate-share hospital to be taken of. So I am just simply saying to you that I think we need to do something to recognize other factors.

I think my State and others should start thinking in terms of reviewing the occupancy of hospitals and the specific needs for access to hospital care as well.

We have got to look at a lot of factors, but I would resist, at this point, saying we are going to measure access to capital strictly on occupancy.

I think we have got to look at other factors and that is what I am going to be doing.

Chairman STARK. Would the gentleman yield, because I think Dr. Vladeck could help. When he ran, or was familiar with the New York system, I think that the rural hospitals in New York State have done well.

I think there is a different problem from most, but I think under the States that have had allocations, certificates of need, whether that is strictly occupancy or not, Jake, those same programs would take into account underserved communities that have no facility.

And I am not so sure that the rural hospitals, under what we are talking about, would not do well. I would like, if he wants to comment——

Mr. PICKLE. Well, I do not think this question is strictly a matter of urban versus rural.

Chairman STARK. No, but I mean the problems that rural hospitals have I think are——

Mr. PICKLE. I know of a hospital in the City of Austin which 2 weeks ago closed down in the middle of a city of nearly half a million people. And I have to say why? Well, it had low occupancy. I think the reason was it was not making money, and it was not just closed because of low occupancy. A lot of factors went into that decision. I think the same thing is happening across the land. So I

think we have got to examine this issue more widely than on just the rate of occupancy and that is what I am going to be looking at. Thank you, Mr. Chairman.

I do not think, however we pay rural hospitals for the capital costs, it's going to speak to their real problems.

I think we do have a particular problem with many rural institutions. I think we have a particular problem with the way the PPS system as a whole treats many rural hospitals. But I am not sure that is a question of the capital payment formula which, after all, is 8 or 10 or 12 percent of their total Medicare revenue.

I think we have to look at much more systematic efforts to address the needs of those institutions whether it is through a different payment system or through some direct subsidization or something else. I think it is important that we do it, but I am not sure that capital payments are going to solve their problems.

Chairman STARK. Mr. Anthony?

Mr. ANTHONY. Thank you, Mr. Chairman.

Mr. Vladeck, just quickly checking. I see that New York has a 78 percent occupancy rate. My own State of Arkansas has 48 percent as of 1987. I do not know what the 1988 number would be. Based on that I have three basic questions I would like you to expound on.

Low occupancy hospitals in my area typically are small and are unlikely to have a full complement of sophisticated technology. In other words they have a below average capital and operating cost per case.

My question is how can a formula be devised to be sensitive to these type of these geographic situations?

Mr. VLADECK. I think, sir, that there are two issues there. One is I think we have to recognize that, although we fight a lot about the definitions that rural hospitals—those that are relatively small institutions but serve a relatively large geographic area have different needs and different problems and different concerns from hospitals in cities or more densely populated suburban areas.

Second, I do not think that occupancy rate should be a key to anything. I think it is a measure we have of whether in the aggregate we have enough capital in a State or not enough capital. I think that is about it. We have to start from the position that Medicare has established controls on everything it pays hospitals except for the capital amount. We need some relatively rational target to shoot at in terms of Medicare capital payments. The place to start a new target is what you are now spending on a State-by-State basis.

You add to that a formula for growth in costs for inflation, market basket, or whatever, and then I do think you have to say some States seem to have a lot more capital than others, and those that have less you probably want to adjust the formula to permit them to catch up. Occupancy comes in at the last part.

I do not think this entire thing is or should be driven by occupancy. It should be driven by some way to try to find an equitable formula for limiting Medicare's total liability, and we do not have one yet.

Mr. ANTHONY. Would it be your opinion that if legislation is passed that reduces Medicare capital payments to the low occupancy hospitals, the result would be redistribution of payments to high

cost hospitals in the Northeast from lower cost hospitals in the Midwest, South, and Southwest?

Mr. VLADECK. It depends on how the legislation works.

We discussed this issue last year, and I believe that it was this committee that asked the Prospective Payment Commission to look at it. The assumption was that the current rules of the game were that any money taken away from low cost hospitals would go into deficit reduction.

I think we ought to start with not having the Federal Government dictate how much to pay each institution for capital. We ought to start with some type of aggregate control based on the State's historical experience, and then at the margin we ought to shift some of those dollars from relatively over-capitalized—that is to say low occupancy States—to high occupancy States recognizing that you have to treat rural areas separately because their needs and their problems are different from those urban areas.

Mr. ANTHONY. Thank you very much.

Chairman STARK. Thank you very much, Beryl.

Mr. ANTHONY. Certainly.

Mrs. Johnson?

Mrs. JOHNSON. Thank you, Mr. Chairman.

I want to ask you one further question, Mr. Vladeck. You commented early in your testimony that as hospital margins are falling hospitals are already having greater difficulty in gaining access to financing, and that suggests, when combined with your first statement, that current capital costs that we are seeing as a result of decisions in the early 1980's, that the decisions hospitals are making now in regard to capital expenditures are different.

First of all is there any evidence at all that they are different and that their capital costs are going to decline as a result of the kinds of decisions that are being made?

Mr. VLADECK. Well our data is very limited, but the little bit I have seen suggests that—it is really the one measure—the volume of public tax exempt issuances for hospital revenue bonds peaked in 1985 and has fallen rather precipitously since then.

Some of that peak was artificial because of the anticipation of a different treatment of tax-exempt income and tax-exempt bonds under tax reform.

My impression and very limited data suggests, however, that there is a lot less new public debt being floated for hospital construction and equipment purposes in the last couple of years than there was in the earlier years of the PPS.

That is very unsystematic, but certainly seems to be a very widely shared perception that there is just less big borrowing going on for capital purposes.

Mrs. JOHNSON. Well, certainly, anecdotally that is what I am hearing from my hospitals. As the reimbursement rates are sinking and the payments are later and later they are having trouble even getting financing for cash flow problems.

I think you make a very good point that we might already be, because we are trying to do policy on the basis of old data, of not seeing the right issue.

Second is there any data from which you can evaluate how much of the appearance cost reduction in the regulated State is real be-

use one result of regulation has been a cost shifting? There has
en a proliferation, for example, of technology in the unregulated
stem because frankly at a certain period of time the process was
aking such irrational decisions that no one could live with them,
d later on came back and reversed themselves.
But during that period there was almost no choice but for vari-
s concerned health care providers to create opportunities in the
ivate sector to provide the care that the certificate of need proc-
s was denying, in a sense, the public sector.
Have there been any studies of how much of that money has
en saved and how much has been shifted? I ask that for a very
al reason because at this point, in Connecticut, where this proc-
s is old and well-developed, we are in absolute chaos. There all
nds of proposals. The process has been changed every 3 years
amatically. This year there are dramatic change proposals, and
e could draw from that that this has not been a highly successful
oject.
I see studies about shifting in my State. But on the national level
w much do you know about the movement of savings from the
gulated sector redeveloping as costs in the unregulated sector?
Mr. VLADECK. I do not know if there has been very much system-
ic data at all. I can tell you that the one bit of unsystematic data
which I am aware is that a lot of these new out-of-hospital activi-
s or services of the sort, that in the regulated States were seen
fleeing outside the regulatory umbrella in terms of technology
services that were set up outside the regulatory apparatus, have
fact proliferated much more quickly in States with very limited
gulatory processes.
So if you look at free-standing MRI's or diagnostic centers of one
rt or another—if you look at free-standing surgical centers—in
t their growth has been greater than in the so-called unregulat-
States than in the regulated States.
Mrs. JOHNSON. Thank you.
Mr. VLADECK. Now what the cost implications are I would not
ow.
f I can make one comment on your earlier point, Mrs. Johnson,
hink your point about the change in behavior in the last couple
years as economic circumstances have changed suggest that
re has to be some symmetrical look at these issues. The issue of
ital financing is not only one of constraining when things are
high, but developing reimbursement policies that will insure
quate infusions of capital when the market or reimbursement
cess is might otherwise lead to underinvestment of capital in
system.
would be hopeful that any policy we came up with should en-
rage more investment in undercapitalized low cost facilities like
ny of our public hospitals, for example.
Mrs. JOHNSON. I should think that would require our being able
lo something about the 2 year data lag.
Mr. VLADECK. No, I think it requires more cleverness in policy
ign than I can think of. But what it needs is a target rate of
dicare capital expenditures and some financing mechanism to
with it. I think we are talking around that today.
Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Mr. Vladeck, I apologize for being late and for missing your testimony.

I have just one or two questions. I have been advocating for sometime putting together a system where we link capital to occupancy. What are your thoughts on that?

Mr. VLADECK. I think that at the individual institutional level occupancy is too manipulatable for that to be a fully desirable kind of approach.

Mr. DONNELLY. Like what, for example?

Mr. VLADECK. It is very easy to decertify a number of beds in a way that makes them readily available again if you want to recertify them if they hit another reimbursement target.

I think, as we were talking a little bit earlier, the issue of occupancy is very different from one part of the country to another—certainly in rural parts of the States as opposed to urban areas of those States, and things of that sort. On the other hand it is not a bad measure at the statewide level of whether—or how badly overcapitalized or how undercapitalized the State's hospital community might be.

Therefore, if we can find some formula that was not totally tied to occupancy, but that took it into account in some way I think that might be certainly better than either an absolute or arbitrary across the board reduction in payments.

Mr. DONNELLY. What about linking capital both to occupancy and heavily disproportionate share hospitals?

Mr. VLADECK. I think that as the market tightens, the need to do something for disproportionate, share hospitals and for certain classes of rural hospitals has become more and more apparent.

On the other hand I am not sure that that is going to be enough. I think we are going to need some other form of credit enhancement for those institutions in addition to reimbursement treatment.

Mr. DONNELLY. Projected over the next 5 years capital payments are going to increase about 100 percent. Why do you think this is so?

Mr. VLADECK. Well, again——

Mr. DONNELLY. Is it because individual States do not have strict enough certificate of need processes?

Mr. VLADECK. I think there are a couple of things. One is I think we are seeing a big effect that we are going to continue feeling for the next 3 or 4 years of investment decisions made in 1983, 1984, and 1985, a lot of them taken in anticipation of tax reform to get in under that wire, and to get in under that PPS wire, and those will ripple through as increased costs for several more years to come.

The second thing is that there is no question that when you control operating reimbursement and do not control in any systematic way capital cost reimbursement, and when institutions can substitute capital expense for noncapital expense, they will do so. There is clearly an effort being made to define as, or create as large a portion of expense on the capital side as possible.

Mr. DONNELLY. Let me ask you a philosophical question.

Why should the Medicare program pay capital reimbursement at all?

Mr. VLADECK. In any accounting definition or in any fair accounting for the costs of the services rendered to the Medicare beneficiaries, the costs of the provision of the capital to render those services would be included.

I think, on the other hand, that this committee——

Mr. DONNELLY. What other health insurance plans in the United States have specific direct passthrough for capital?

Mr. VLADECK. I do not know where we are now in terms of the movement away from cost-based, but certainly throughout the 1970's and first part of the 1980's those Blue Cross plans that were paying on a cost basis included explicit recognition of capital cost. Most State Medicaid plans did.

And to the extent that people paid hospital charges; it is a safe presumption that those charge structures incorporated capital costs as well.

So third parties have been paying capital pretty much across the board for the last 20 years at least, and Medicare sort of lead the way but has brought everyone else along with them in that regard.

Mr. DONNELLY. Thank you very much.

Mr. VLADECK. Pleasure.

Chairman STARK. Thank you very much, Bruce.

Our next witnesses will comprise a panel. Mr. Keith Anderson who is the Special Assistant to the Director of the Bureau of Economics in the Federal Trade Commission, and Dr. James R. Kimmey, who is the director of the Center for Health Services, Education and Research at the St. Louis University Medical Center.

We welcome these two witnesses to the committee, and ask them to proceed in the order in which their names appear on the witness list. Their prepared statements without objection will appear in their entirety in the record.

You may proceed, Mr. Anderson, to enlighten us in any way you are comfortable.

STATEMENT OF KEITH B. ANDERSON, SPECIAL ASSISTANT TO THE DIRECTOR, BUREAU OF ECONOMICS, FEDERAL TRADE COMMISSION, ACCOMPANIED BY PAUL PAULTER, DEPUTY DIRECTOR, ECONOMIC POLICY ANALYSIS

Mr. ANDERSON. Mr. Chairman, members of the committee, it is a pleasure to be here today to discuss the effectiveness of certificate of need regulation of health care facilities.

As you said, Mr. Chairman, my name is Keith Anderson. I am Special Assistant to the Director of the Bureau of Economics of the Federal Trade Commission. With me today is Paul Paulter, Deputy Director for Economic Policy Analysis in the Bureau of Economics.

With your permission I will offer a brief statement on behalf of the Commission. After that, recognizing the unusually technical nature of this subject, the Commission has authorized me to respond to any questions that you may have. In doing so I will be expressing my personal views and not necessarily the views of the Commission or any of its members. I am also providing you with copies of testimony on this subject that I have presented on behalf of the Commission's Bureau of Economics in response to a recent

request from the North Carolina State Goals and Policy Board. This testimony was not adopted by the Commission.

The Commission is aware that existing CON regulations is not exactly the same as the regulatory regime envisioned in H.R. 712. Therefore the effects of the proposed scheme may differ from what we have observed with certificate of need. However, we hope that the Commission's analysis on CON regulation will be of use to the committee in its deliberations on H.R. 712.

Three factors suggest that certificate of need regulation has been ineffective and undesirable. First, a number of economic studies, some of which have been done by the staff of the Commission's Bureau of Economics, have concluded that CON regulations have not been effective in reducing health care costs. Second, the Commission believes that certificate of need regulations may have competitive effects. Third, the Commission believes that changes in the way health care services are provided and in health insurance are increasing the ability of health care markets to function in an unregulated competitive environment.

At least 16 studies of the effectiveness of certificate of need regulation have appeared in the last 15 years. Three of these studies were written by the staff of the Commission's Bureau of Economics. These economic studies are in near total agreement that certificate of need regulation does not achieve the goal of lowering the cost of health care. While a few studies do find some reduction in hospital beds where there is CON regulation, overall the studies find that the costs of health care are no lower where there is certificate of need. Some studies find costs are the same whether or not CON regulations are present. Others find that costs are actually higher where there is CON regulation. A majority of these studies have examined the effect of CON on hospital services, however similar results have been found in studies of nursing homes, and of firms providing home health care services. In addition, a theoretical analysis of CON regulation suggests that even if this form of regulation worked perfectly it may not reduce the costs of a stay in the hospital.

The CON regulatory process may increase prices to consumers by impeding entry and thus protecting health care providers from competition. CON also reduces the possibility of entry by firms that might provide services of higher quality or lower cost than the existing firms, and that might replace providers that are not effectively meeting consumer needs. CON regulation may also interfere with competition and improvements in the quality of care by delaying the introduction and acceptance of alternatives to costly, less effective treatment methods.

Because certificate of need regulation delays or reduces the prospect of new entry and expansion, it increases the likelihood that providers will exploit whatever market power they have to raise prices above or reduce quality below the competitive level. That is why the Commission has cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anticompetitive effects from hospital mergers.

To the extent that CON regulation reduces the supply of particular health services below competitive levels, prices for these services can be expected to be higher than they would be in an unregu-

lated market. Curtailing services or facilities may force some consumers to resort to more expensive or less desirable substitutes, thus increasing costs for patients or third party payers. For example, if nursing home beds are not available, the discharge of patients from more expensive acute care hospital beds may be delayed or patients may be forced to use nursing homes far away from home.

Certificate of need regulation was imposed in part in the belief that consumers lacked adequate incentives to seek out lower cost health care. It was observed that the patients did not directly pay for the cost of the health care services they consumed, and that the private and government insurers, who did pay the bills generally reimbursed the provider for whatever costs were incurred in caring for each individual patient.

As a result, proponents of CON regulation argued that providers did not have sufficient incentives to keep their costs down. However, recent changes in health care markets have altered these incentives, and should, therefore, increase the likelihood that unregulated competition will provide health care services efficiently.

While private and public insurance still pay for the vast majority of health care, consumers and employers have become more sensitive to the costs of health insurance, and have therefore sought ways to increase incentives for health care providers to provide quality care at the lowest possible cost.

The Commission's written statement contains some of the evidence on the changes that have occurred. These changes have affected the demand for health care. Between 1975 and 1986 hospital usage rates declined more than one-third. While some of this decline was probably the result of technological change in health care, economic incentives also appeared to play an important role. Before Medicare introduced its prospective reimbursement system, hospital usage rates declined more slowly for senior citizens than for younger patients. Between 1983, when prospective reimbursement was introduced, and 1986, the most recent year that I have data, senior citizen usage declined at 8.3 percent per year, the same rate as for the population at large.

As consumers and health insurers become more cost conscious, hospitals with inflated costs and prices will increasingly risk losing business. This is particularly true where HMO's and PPO's can direct their large number of patients to hospitals that charge lower fees.

Thus the growing cost sensitivity of consumers and health insurers should increase incentives for hospitals to provide quality service at the lowest possible price.

In conclusion, the available economic evidence suggests that CON regulations have not been successful in controlling health care costs. CON may have anticompetitive effects. Recent changes in health care markets should be increasing the ability of health care markets to function in an unregulated competitive environment.

This completes the Commission's statement. I will be pleased to attempt to answer any questions you may have based on my own personal expertise.

[The statement of Mr. Anderson follows:]

Statement of Keith B. Anderson, Special Assistant to the Director, Bureau of Economics, Federal Trade Commission

Mr. Chairman, my name is Keith Anderson. I am Special Assistant to the Director of the Bureau of Economics of the Federal Trade Commission. It is a pleasure to be here today. With your permission, I will offer a brief statement on behalf of the Commission. After that, recognizing the unusually technical nature of this subject, the Commission has authorized me to respond to any questions you may have. In doing so, I will be expressing my personal views and not necessarily the views of the Commission or any of its members. I am also providing you with copies of testimony on this subject that I presented on behalf of the Commission's Bureau of Economics in response to a recent request from the North Carolina State Goals and Policy Board. This testimony was not adopted by the Commission.

I will now address briefly the effect of state Certificate of Need, or CON, regulation. The Commission is aware that existing CON regulation is not exactly the same as the regulatory regime envisioned in H.R. 712, the "Medicare Inpatient Hospital Capital Expenditures Amendments of 1989," and therefore, the effects of the proposed scheme may differ from what we have observed with Certificate of Need. However, we hope that the Commission's analysis of CON regulation will be of use to the Committee in its deliberations on H.R. 712.

Three factors suggest that Certificate of Need regulation has been ineffective and undesirable. First, a number of economic studies, some of which have been done by the staff of the Commission's Bureau of Economics, have concluded that CON regulations have not been effective in reducing health care costs. Second, the Commission believes that Certificate of Need regulations may have anticompetitive effects. Third, the Commission believes that changes in the way health care services are provided and in health insurance are increasing the ability of health care markets to function in an unregulated, competitive environment.

Allow me to expand briefly on each of these points.

A. The Available Economic Evidence Suggests That Certificate of Need Regulation Has Not Been Effective in Reducing the Costs of Health Care.

At least sixteen studies of the effectiveness of Certificate of Need regulation in reducing the cost of providing health care services have appeared in the last fifteen years. Three of these studies were written by the staff of the Commission's Bureau of Economics.

These economic studies are in near total agreement that Certificate of Need regulation does not achieve the goal of lowering the costs of health care. While a few studies do find some reduction in hospital beds where there is CON regulation, overall the studies find that the costs of health care are no lower where there is Certificate of Need: some studies find costs are the same whether or not CON regulations are present, others find that costs are actually higher where there is CON regulation. The majority of these studies have examined the effect of CON on hospital services. However, similar results have been found in studies of nursing homes and of firms providing home health care services. In addition, a recent theoretical analysis of CON regulation suggests that, even if CON worked perfectly, it may not reduce the costs of a stay in the hospital.

B. CON Regulation Interferes with Competition and Innovation in Health Care Markets.

The CON regulatory process may increase prices to consumers by impeding entry, and thus protecting health care providers from competition. CON also reduces the possibility of entry by firms that might provide services of higher quality or lower cost than existing firms and that might replace providers that are not effectively meeting consumer needs. CON regulation may also interfere with competition and improvements in the quality of care by delaying the introduction and acceptance of innovative alternatives to costly, less-effective treatment methods.

Because Certificate of Need regulation delays or reduces the prospect of new entry and expansion, it increases the likelihood that providers will exploit whatever market power they have, individually or collectively, to

raise prices above, or reduce quality below, the competitive level. That is why the Federal Trade Commission has cited the entry barrier created by CON regulation as a factor significantly contributing to the potential for anticompetitive effects from hospital mergers.[1]

To the extent that CON regulation reduces the supply of particular health services below competitive levels, prices for these services can be expected to be higher than they would be in an unregulated market. Curtailing services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party payers. For example, if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use nursing homes far from home.

C. Health Care Markets Are Now More Able to Function Effectively Without Certificate of Need Regulation.

Certificate of Need regulation was imposed, in part, in the belief that consumers lacked adequate incentives to seek out lower cost health care. It was observed that patients did not directly pay for the cost of the health care services they consumed and that the private and government insurers who did pay the bills generally reimbursed the provider for whatever costs were incurred in caring for each individual patient. As a result, proponents of CON regulation argued that providers did not have sufficient incentives to keep their costs down. Indeed, the reason that CON regulation has been ineffective in controlling health care costs may be the fact that CON does not alter the incentives of consumers or health care providers.

However, recent changes in health care markets have altered these incentives and therefore should increase the likelihood that unregulated competition will provide health care services efficiently. While private and public insurance still pay for the vast majority of health care, consumers and employers have become more sensitive to the costs of health insurance and have therefore sought ways to increase incentives for health care providers to provide quality care at the lowest possible cost.

One indication of this increased attention to cost control is the growth in health maintenance organizations (HMOs) and preferred provider organizations (PPOs). PPOs and HMOs tend to promote cost-containment by encouraging, or requiring, patients to use cost conscious providers. In 1988, HMO enrollment was 31.4 million.[2] This represented more than a five-fold increase from the 6.0 million enrolled in 1976.[3] Similarly, an estimated total of 45 to 50 million people currently have the option of using a preferred provider.[4] In December 1984, only 1.3 million were enrolled in plans with a PPO option.[5]

Increased sensitivity to health care costs is also reflected in the percentage of firm health plans requiring insurer approval before admitting a

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[1] American Medical International, 104 F.T.C. at 200-201 (1984); Hospital Corporation of America [Chattanooga acquisitions], 106 F.T.C. at 489-496. In affirming the Commission's decision in Hospital Corporation of America, Judge Posner agreed that CON regulation can create a barrier to entry. (Hospital Corporation of America v. Federal Trade Commission, 807 F.2d. 1381, 1387 (7th Circuit, 1987))

[2] As of June 1988, there were 643 HMOs in the United States. (Telephone interview with David Glazer of InterStudy, February 10, 1989.)

[3] *Health, United States, 1987*, table 112, p. 170.

[4] There are currently 637 PPOs in operation in the U.S. (Telephone interview with Ed Pickens, American Medical Care and Review, February 10, 1989.)

[5] Jon Gabel, Dan Ermann, Thomas Rice, and Gregory de Lissovoy (1984), "The Emergence and Future of PPOs," *Journal of Health Politics, Policy and Law*, 11 (Summer), p. 306.

patient to a hospital or requiring second opinions prior to surgery. By 1987, preadmission certification was required by over one-third of company-offered health plans,[6] compared with 2 percent in 1982.[7] In 1987, more than 40 percent of employee health plans mandated a second opinion prior to surgery,[8] while only 28 percent of plans did so in 1984.[9] Finally, the use of copayments and deductibles in private health insurance plans has increased.[10] These changes increase incentives for consumers to purchase less expensive health care and forgo unnecessary treatments.

Government-funded programs have also introduced changes. As you are well aware, the Medicare system has converted payment of hospital operating costs to a prospective payment approach. Many states have been experimenting with cost containment strategies for their Medicaid programs. Several states have begun using HMOs or other capitation and case management strategies to provide care to Medicaid patients.[11] Some states have used prospective reimbursement plans to pay for nursing home costs.[12]

These changes have affected the demand for health care. Between 1975 and 1986, hospital usage rates declined more than one-third.[13] While some of this decline was probably the result of technological change in health care, economic incentives also appear to have played an important role. Before Medicare introduced its prospective reimbursement system, hospital usage rates declined more slowly for senior citizens than for younger patients. Between 1983 -- when prospective reimbursement was introduced -- and 1986 -- the most recent year for which I have data -- senior citizen

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[6] Steven DiCarlo and Jon Gabel (1988), "Conventional Health Plans: A Decade Later," Research Bulletin, Health Insurance Association of America, p. 11.

[7] Jeff Goldsmith (1984), "Death of a Paradigm: The Challenge of Competition," *Health Affairs*, 3 (Fall), p. 14.

[8] DiCarlo and Gabel (1988), p. 11. Moreover, an additional 10 percent required a second opinion in some cases.

[9] Goldsmith (1984), p. 14.

[10] Between 1982 and 1984, the percentage of insurance plans paying 100 percent of hospital charges for the first days of hospital care fell from 67 percent to 42 percent. The percentage paying 100 percent of surgical fees fell from 42 percent to 26 percent. In 1982, only 4 percent of plans required an annual deductible of $200 or more per family. (Goldsmith (1984), p. 12) By 1987, the average plan had an deductible of $330. (Computed from figures in DiCarlo and Gabel (1988), p. 14.)

[11] Under a capitation plan, a provider receives a fixed payment per month which depends on the number of covered patients who select that firm or individual as their primary care provider. This payment is independent of the costs of any care provided to any particular patient. In some cases, states have used partial capitation plans where the provider receives a fixed fee to cover some set of basic services. However, additional payments are made if the patient needs care not covered under the capitation agreement. (Deborah A. Freund and Edward Neuschler (1986), "Overview of Medicaid Capitation and Case-Management Initiatives," *Health Care Financing Review*, (Annual Supplement), pp. 21-30)

[12] James H. Swan, Charlene Harrington, and Leslie A. Grant (1988), "State Medicaid Reimbursement of Nursing Homes, 1978-86," *Health Care Financing Review*, 9 (Spring), pp. 33-50.

[13] In 1975, the rate of hospital use was 1,254.9 days of care per 1,000 persons. (National Center for Health Statistics, *Health, United States, 1978*, DHEW Publication No. (PHS) 78-1232, Public Health Service, U.S. Government Printing Office, 1978, table 101, p. 308) In 1986, the rate was only 833.1 days of care per 1,000 persons. (National Center for Health Statistics, *Health, United States, 1987*, DHHS Publication No. (PHS) 88-1232, Public Health Service, U.S. Government Printing Office, 1988, table 63, p. 109)

usage declined at 8.3 percent per year, the same rate as for the population at large.[14]

As consumers and health insurers become more cost-conscious, hospitals with inflated costs and prices will increasingly risk losing business. This is particularly true where HMOs and PPOs can direct their large numbers of patients to hospitals that charge lower fees. Thus, the growing cost sensitivity of consumers and health insurers should increase incentives for hospitals to provide quality service at the lowest possible price.

D. Conclusion

In conclusion, the available economic evidence suggests that CON regulation has not been successful in controlling health care costs. CON may have anticompetitive effects. Recent changes in health care markets should be increasing the ability of health care markets to function in an unregulated, competitive environment.

This completes the Commission's statement. I would be pleased to attempt to answer any questions you may have, based on my personal expertise.

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[14] Between 1975 and 1980, hospital use by persons aged 65 and above declined at a rate of 0.33 percent per year. For the population as a whole, the rate of decline was 1.98 percent. Between 1980 and 1983, the rate of decline was 0.77 percent per year for seniors and 2.05 percent for the population as a whole. (Based on data in *Health, United States, 1978*, table 101, p. 308, and *Health, United States, 1987*, table 63, p. 109.)

Mr. DONNELLY [presiding]. Dr. Kimmey.

STATEMENT OF JAMES R. KIMMEY, M.D., PROFESSOR OF COMMUNITY HEALTH, AND DIRECTOR, CENTER FOR HEALTH SERVICES EDUCATION AND RESEARCH, ST. LOUIS UNIVERSITY MEDICAL CENTER

Dr. KIMMEY. Thank you.

I am Dr. James Kimmey, a professor of community health and director of the Center for Health Services Education and Research of St. Louis University. I have been in that position for the past 2 years. I think I am here since for about 20 years I have been involved in planning and regulatory activities at the Federal and State level, both as a member of the Public Health Service, and later as director of these activities for the State of Wisconsin. Subsequent to that I was involved as the director for the Institute of Health Planning, a firm which did training, offered technical assistance, and developed programs in health planning and regulation.

I have submitted a prepared statement, which I will not rehash. I would like to emphasize a couple of points in that statement.

First I would like to put out my biases on this matter. I am not an economist. I do not believe that regulation is inherently bad, and nor do I believe the market is inherently good or vice versa. I think that I would characterize myself as a policy person more oriented to the public policy aspects of some of these programs.

The arguments over the methods of studying certificate of need could go on and take up your entire agenda. We could go through a variety of differences among the certificate of need programs from State-to-State. These include problems with the time at which those programs were introduced relative to the size of the capital needs within that State. If you introduce certificate of need when the capital needs for replacement/renovation are very high, the program might look like a high-volume and unsuccessful program. If you introduce the program at a time when capital needs are very low, the program might well look as if it was tremendously effective in keeping capital expenditures down.

There are a number of similar factors that have entered into a series of criticisms of the studies of the effectiveness of the certificate of need process done in the past.

But I think the arguments over the methods miss the point. Clearly there are wide variations in the effectiveness of the certificate of need programs from State to State and over time. I think the more interesting question is why.

First, the mandate, I believe, particularly the Federal mandate for the certificate of need, was never very clearly drawn. Different States enacted certificate of need laws for reasons that had nothing to do with a specific goal of containment of health care costs.

States were interested in the distribution of health services within the State. They were interested in some of the issues that had been identified by the panel earlier, rural/urban distribution of such services. They were interested in learning more about the investments that were being made in the health field within the

State, and they saw the review mechanism as one method of doing these things.

One of the variations in recent studies that has been cited as the criterion for stringency is the threshold for review. Thresholds for review varied, at least in my experience, for reasons other than the establishing the stringency of the legislation. A low threshold for review provided a planning agency with maximum opportunity to review the investment strategies of institutions in the field and to be able to see how well those institutions were responding to the needs of the State or the community as identified in planning.

High review thresholds in my experience, have been used more often to keep the volume of reviews down because of understaffed agencies and problems in conducting adequate review rather than reflecting the level of stringency.

The review threshold as the stringency measure, I think, has little to commend it. A better measure of stringency was identified by Cohodes in his work in the early 1980's in which he referred to the "regulatory will" of the State. That topic came up in the committee in discussions of New York, Connecticut, and some of the other highly regulatory Northeastern States, versus States like Louisiana that never enacted a certificate of need law.

States that had a high degree of regulatory will tended to have a health care system of considerable size, a large problem with indigent care, distribution problems, and a tradition of using regulatory approaches, tended to do better with these programs and have more stringent review regardless of the thresholds that they used for the review process.

Unfortunately, as many students of this field have pointed out, it is very difficult to measure regulatory will. It is not a quantifiable issue. Nevertheless, those of us who are active in the field and have observed these programs over time feel that this is a significant factor.

The third point I would make is that CON programs, and particularly those that were federally mandated were open-ended programs. There was no limit on the number or dollar amount of certificates which could be issued by a given State over a given period of time. Therefore, if the State lacked regulatory will, there really was no pressure on that State to contain the volume of capital investment within the State. They could simply issue certificates as the projects came down the line, and indeed some States did follow that kind of path.

Finally there is tremendous structural variation in the programs. The scope of coverage, the review threshold which we have already mentioned, the penalties that are associated with the programs—all show tremendous variations. As a result, it is very difficult to judge the effectiveness or ineffectiveness of these programs without getting into extremely complex analysis.

Nevertheless, these are not the questions. The real question is determining the effect the changing, more competitive environment in the health care field. As was pointed out by an earlier witness, demand was down a third during a 10-year period from the mid-1970's to the mid-1980's. I would point out that during that same period the number of uninsured Americans was up by 17 million.

Now, I think this kind of effect, the increase in uninsured is a direct result of efforts to install a more competitive system when a number of people have no way of gaining access to that system. Such individuals have no way of "voting with their dollars" to determine what project should and should not be developed, or what directions that system could go.

I do believe that a competitive system could work in this Nation if we had universal entitlement or national health insurance. Short of that ideal which provides all people the access to the system that allows them to make economically active decisions, we cannot deal with this system as if it was truly competitive.

Rather, I think, we get to the point that Prof. Ewe Reinhardt has suggested, a situation of regulated competition. The point then becomes, how do you regulate the competition in the industry. I would suggest that regulating capital, where there is no control at this point in time and no prospect that it will be put into a more competitive model, is one way of regulating the system in a way that may be more effective in achieving some of the distributional effects that many of the designers of these programs were after in the first place.

Thank you very much. I will be very happy to answer any of your questions.

[The statement of Dr. Kimmey follows:]

Statement of James R. Kimmey, M.D., St. Louis University Medical Center

I am Dr. James R. Kimmey, currently Professor of Community Health and Director of the Center for Health Services Education and Research at the St. Louis University Medical Center in St. Louis, Missouri. Prior to joining the faculty at the Center in 1987, I spent ten years as the President of the Institute for Health Planning, a not-for-profit organization located in Madison, Wisconsin, which provided technical assistance and training in planning, policy development, and health services regulation to federal, state, and local agencies and organizations. Immediately before joining the Institute, I spent three years as Director of the Division of Health Policy and Planning of the State of Wisconsin, directing that state's cost containment efforts in the health arena. I have spent the last twenty years involved in managing, studying, and teaching in the health policy and planning field.

It is against that background of interest and experience that I accepted the invitation to appear before your subcommittee today and discuss the role of government in regulating the health care system, and particularly capital investment in that system.

The History of Capital Regulation

Regulation of capital expenditures of health care institutions using the certificate of need concept originated at the state level. States which experienced cost problems early, or which considered control over distribution of services and facilities a priority, borrowed the concept from public utility regulation. They recognized that the health sector was different from other sectors in its economic structure and incentives, and in its social role. They accepted the idea that there was a public interest in the health system's structure and operations which was not being served by decentralized independent decision-making on investment.

A number of factors influenced the development of state programs of capital expenditure controls in health care. These included the size of the industry in a state; a state's political tradition; its cost experience; and the perception of trends in institutional development in a state. Despite the general unpopularity of regulation as a means to assure the public interest, more than half the states independently enacted certificate of need programs in the 1964-1974 decade.

The federal government entered the arena with a voluntary program in 1972 [Section 1122 of the Social Security Act] and a mandatory program in 1974 [P.L. 93-641]. Under the impetus of the federal mandate, all but one state established certificate of need programs. These programs, although they met minimum standards set in federal statute and regulation, varied widely. As when states were independently developing their programs, the shape and effectiveness of the mandated programs reflected each state's unique combination of resources, history, and projected growth. The philosophies underlying specific state programs ranged from sector development through resource distribution to cost containment.

Beginning in 1980, the federal administration began actively to seek elimination of federally-mandated and supported state regulation of capital investment in the health industry. Although the Congress acted to maintain the programs and their support in the early Eighties, states have had the option since 1982 to either eliminate certificate of need or substantially change the programs. Although a number of states have either repealed their laws or allowed them to "sunset", thirty-seven states retain a capital expenditure review program of some type. They have maintained a staff planning and review capability sufficient to meet the state's perceived needs in this area.

The basis for opposition to certificate of need as an approach to controlling capital investment in the health sector has varied over time depending largely on the characteristics of the reimbursement system. When reimbursement was cost-based, the opposition was largely philosophical, based in the general societal dislike of "command and control" regulation and the health sector's traditional dislike for governmental interventions in its affairs. With the changes in reimbursement which have occurred over the past decade, the philosophical position has been buttressed by those who contend that the combination of prospective reimbursement by the federal government and prudent purchasing by the private sector creates a situation in which institutions must make economically-rational investment decisions in order to survive, rendering regulation of those decisions unnecessary as well as undesirable.

This position reflects a narrow understanding of the intent and function of certificate of need and the planning systems which supported it. The idea that certificate of need programs by themselves would control operating costs in the health industry gained currency relatively late in the history of the programs. The motivation for states which enacted certificate of need independent of the federal mandate was at least equally to improve distribution of facilities and services and to eliminate unnecessary duplication of services for quality as well as cost reasons. It was not until it was apparent that other elements of a cost control program--specifically rate review--could not be enacted as a federal mandate that the federal managers of the health planning system began emphasizing the cost containment function, almost to the exclusion of other aspects which had been a part of health planning from its inception as a voluntary community based effort in the late thirties.

Changing expectations concerning certificate of need and health planning as the "front line" in health care cost containment placed these programs in a difficult position. They were asked to prove their worth on the basis of cost containment in the system as a whole. The programs were not designed with this goal in mind, nor were the tools provided to permit them to function effectively in this way. A program designed to channel development of the health system in a state to improve its effectiveness and efficiency was being judged on the basis of its effectiveness in constraining that development.

General Characteristics of Capital Review Programs

Certificate of need programs, both those developed independently and those developed in response to the federal mandate, had certain common characteristics:

Defined scope of coverage--A statement of the types of facilities, equipment, or services which were subject to the requirements of the program, and those which were excluded from such coverage.

Threshold for review--A dollar amount which must be exceeded before a specific project falling within the scope of the program would be subject to review.

Plan-based decisions--A requirement that proposals be compared to some set of standards and needs derived from an open process involving public input.

Due process requirements--Provisions defining minimum requirements assuring that the review of proposals and granting of certificates would be an open process, and defining rights to administrative and judicial review of decisions.

Penalties for non-compliance--Provisions defining sanctions to be applied if an organization subject to the requirements of the

program failed to obtain the necessary approvals, or proceeded with a project in the face of a negative review.

Effects of Variation Across States

There was wide variation among state programs in each of these areas, creating a situation in which comparisons across jurisdictions was difficult.

For example, the scope of coverage varied substantially from state to state. Some emphasized hospitals and other inpatient facilities, while others extended coverage to outpatient facilities and services. The federal regulations governing these programs after 1975 brought a degree of uniformity of scope, but also restricted the scope in some areas. Appropriately, there was never a uniform scope of coverage across the state programs.

The thresholds for review were another area of variation. Initially, some states used much lower thresholds than others, and varied the thresholds by type of facility or service. Again, the imposition of federal thresholds for complying programs brought a degree of uniformity, and states which, for planning and distribution reasons, wished to review a broader range of projects were allowed to use thresholds lower than the federal level. The threshold has been used in some retrospective reviews of CON programs as a surrogate for stringency. I feel this interpretation is inconsistent with the situation at the time. The threshold was used more frequently to either broaden the scope of the state's overview of developments in the system (low threshold) or to limit the volume of review activity (high threshold). Program stringency was, as Cohodes pointed out, a function of the state's "regulatory will", not its threshold for review.

The characteristic of plan-based review was also the source of wide variation. Despite the existence of federal regulations defining the plan and providing broad review criteria, there was very wide variation among jurisdictions in the specificity of the planning documents, and their application in the review and decision process. Some states developed very specific documents supported by detailed guidelines for various covered projects; others operated on the basis of broad planning documents, leaving interpretation of the applicability to a given project to the review process.

Although there were variations in due process based on different state administrative practices acts and in penalties for non-compliance, these were probably less significant in determining the effect of a state program that the preceding factors.

Analysis was further complicated by coexistence of other regulatory programs, particularly rate review, in selected states.

Donald Cohodes identified several other factors which made studies of the impact of certificate of need difficult. These include the cyclical nature of hospital investment and the time lag between a decision to invest and the completion of the project. The former characteristic can affect the perceived effectiveness of a specific state's efforts, since a program instituted when the facility stock is relatively new will deal with fewer and smaller projects than on instituted when stock is obsolescent and requires replacement for safety and quality reasons. The latter is significant because it severely limits the ability to assess effects of a certificate of need program along any dimension on less than a five year time scale. Thus, for example, any effects on costs experienced in 1983 would be related to certificate of need decisions made as early as 1978.

Despite these problems with studying the effects of certificate of need, there have been many attempts to determine its effects on health care costs. In virtually every case, these studies

have found that certificate of need programs have failed to contain health care costs. In every instance, the design of the study can be questioned on the basis of the types of concerns outlined above. To my knowledge, no study of the effect of certificate of need has been designed which deals effectively with the multiple variables in the process itself.

Lessons From Past Experience

I believe that arguments over methodology miss the point in dealing with the question of whether or not government should take an active role in planning and regulating capital investment in the health sector. I believe that one must accept that, even with the methodological flaws and bias exhibited in studies of certificate of need, the programs have had little effect on health care costs. The more interesting question to me is--why is that so?

There are several observations in this regard

1. The mandate of the certificate of need effort in the 1975-85 period was never clearly drawn. Different actors had very different perceptions of their roles. As a result, agencies who saw their role as development and distribution of resources in a more rational and cost effective fashion were unresponsive when tasked to restrain growth in the health sector.

2. As indicated earlier, there has always been substantial variation among the states in the approach to these programs. Although the federal government could be aggressive in mandating program parameters and assuring compliance with such parameters by the states, this has always been a sensitive area. States are generally resentful of stringent procedural and decision-making rules.

3. This variation might not be a problem if all states had a strong commitment to directing capital investment ["regulatory will" as Cohodes calls it]. The experience in the program over ten years demonstrated a wide variation in this commitment, and this in turn was a major factor in the perceived "success" or "failure" of the program. Cohodes points out that the federal government cannot force this commitment on a state, and that creating it is a formidable challenge.

4. Certificate of need as mandated by P.L. 93-641 was an "open-ended" program. There was no limit on the total allowable investment in the system in a state in a given year, allowing states with low commitment levels to issue certificates with no restraint. Institution of a "capital cap" was a feature of the Carter Administration's Hospital Cost Containment proposals in the late Seventies, one that was strongly opposed by the industry. A cap approach would clearly strengthen a program's ability to constrain growth, and force a type of trade-off among competing proposals which was never realized under the earlier federally-mandated program.

5. Certificate of need programs under the mandate were insufficiently broad in their scope of coverage, and offered substantial opportunities for "creative avoidance". Ample examples of this feature exist in areas such as diagnostic imaging.

6. Except in a few states which developed rate review programs on their own, the capital expenditure review was not linked to controls over operating costs. The studies which do show a cost restraining effect for certificate of need are all based on the experience in such heavily regulated environments.

In short, the regulatory approach to the health industry as practiced in the Sixties and Seventies was relatively ineffective as a cost containment measure, not because it was inherently flawed, but because it was disjointed and incomplete. In

retrospect, this deficiency was predictable given the factors of general dislike of regulation as a policy tool, lack of strong commitment to a regulatory approach in many jurisdictions , and the strength of industry opposition. It is highly unlikely that the industry would tolerate regulation at the level of stringency required to assure success of a totally regulatory approach in affecting costs. Further, the administrative costs would be substantial.

If one accepts this indictment of the regulatory approach as formerly practiced in health care, is there any role for regulation in the current health care environment? The answer, I believe, is a qualified "yes".

We are now near the end of a decade of "competition" in the health care industry. And the health care system has changed as a result. Hospitals have changed--they have diversified into "product line" management; have invested in "boutique services"; are running large advertising budgets to attract "customers"; are discounting charges to large purchasers; and are maintaining or improving their financial position in many cases despite historical low occupancies. Physicians are increasingly practicing in organized settings such as HMOs, or marketing their services at favorable rates through PPOs.

There is a price for increased competitiveness in the health system. The most obvious price is paid by those who can't "vote with their dollars", seeking the care they require from the most competitive provider. While the various components of the pluralistic competitive solution--DRG reimbursement and prudent purchasing--have restrained cost increases for those governmental and business entities which are sufficiently large to exercise leverage, they have contributed nothing to those in the population who are uninsured. As private non-profit hospitals have found it necessary to cut back on uncompensated care, an increasing burden has shifted to the public hospitals, already in trouble. Changes in employment and in Medicaid eligibility policies have isolated increasing numbers of Americans from even the most basic health care. The "low estimate" of the uninsured--31 million--is still too high, and has increased substantially since 1980.

The drift toward investment in technology rather than basic health services has accelerated in the unregulated era. The proponents of an unregulated approach to capital investment hold that hospitals will consider capital investments more carefully in terms of their effect on the institution's overall financial picture in absence of regulatory constraints. They are correct--institutions are investing heavily in new services--eye centers, obesity centers, cosmetic surgery centers, fitness centers, to name a few. There is no attention to community-wide relative priorities and needs--only to programs which attract patients who are self-pay or insured for low-cost high-margin programs. This is in no way an indictment of hospitals--they are responding to the new incentives in the system in ways that are predictable and conducive to organizational survival. Such decisions have little to do with the broader needs of a community for health services, however, and consume resources which might be better applied in other areas.

Investment decisions are also driven by an inconsistency in the fabric of a more competitive health market, the absence of linkage between reimbursement and capital. The DRG program, largest single payor for health services, was designed without a capital component, and after five years, capital costs continue to be treated as a pass-through. With the demise of planning and regulation in many jurisdictions, the result has been a lack of incentives for institutions to make investment decisions on either economic grounds (they are reimbursed on costs) or on community need grounds (there is no external review and control).

In the end, the question of free market versus regulated market in health care is rhetorical. Substantial forces would be arrayed against either a total regulation or a total competition approach to the health industry, and neither approach can demonstrate a track record of success which supports its adoption to the exclusion of the other. Professor Uwe Reinhardt of Princeton predicted a stabilization of the system in a state of "regulated competition", perhaps as accurate a characterization as is possible of the direction things are moving.

The public, in my view, has an interest in the organization and delivery of health services which cannot be fully realized in a market setting absent universal entitlement. The current situation, in which capital costs are reimbursed by the largest payor without regard to either market factors or community needs violates that public interest. Capital expenditure review by a state, provided it is based on carefully developed plans, and is structured in such a way as to avoid some of the defects inherent in the earlier federally-mandated program, would provide a way of assuring that interest, which is not now present in the health system nationally. The question is not so much what a program did or didn't accomplish in the past as it is whether a more limited program with clearer objectives can deal with the problems of the present and the future.

Mr. DONNELLY. Thank you very much. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Anderson, you said that the certificate of need program really has not worked, really has not been effective, has not controlled costs, and that it may have even had some effect on competition.

In view of the fact that you say that the certificate of need have not worked, what is your assessment of Mr. Stark's proposal to control capital payments based on occupancy rates?

Mr. ANDERSON. Mr. Pickle, I have not had the opportunity to study Mr. Stark's bill in any detail.

We were asked to discuss the evidence on CON. To the extent that Mr. Stark's proposal would work like CON, I think that may tell you something, but beyond that, I am afraid I am not prepared to go into it.

Mr. PICKLE. Well, you have come up here today saying that these are your own views. You were instructed to talk about the certificate of need and not the other aspects of this proposal. Is that correct?

Mr. ANDERSON. I am not comfortable talking about the other aspects of it.

Mr. PICKLE. Well, I am not comfortable with you just blowing a kiss at us either.

I do not mean that critically. I am just saying that I would hope to get the Federal Trade Commission's views if it has any views.

I recognize that you are limited primarily to the other certificate of need issue.

You are saying, in fact, that it is not working, but you do not have a view from the Commission regarding whether this other approach would work either.

If they do have a position on this approach, would you pass that on to us?

Mr. ANDERSON. Certainly.

Mr. PICKLE. All right. Do you think that the certificate of need regulations have kept new providers out of this market, or maybe have kept new technology out of the market place?

What would be the impact of a statewide cap based on occupancy as recommended by Mr. Stark? Do you have any view on that either?

Mr. ANDERSON. A statewide cap on occupancy. I am not sure——

Mr. PICKLE. Well, statewide cap on capital investments.

Mr. ANDERSON. It is difficult to tell how that would work. Certainly, it could have the same kind of effect. It would probably depend on how the State chose to allocate the capital that they had available.

Mr. PICKLE. All right. Thank you.

Dr. Kimmey, I find your testimony interesting to the extent that you have really given some reasons why the certificate program has not worked. You have listed about four or five different reasons why that may have happened.

I think that comes near exploring what I am looking for.

Why has this process not been effective? Perhaps your approach may be a good one for the committee to look into.

I find your testimony interesting.

Dr. KIMMEY. I think that the reason the certificate of need was not effective in containing costs of health care was because that was not the purpose for which program was initially designed. Once the political decision was made that cost control was what it was expected to do, which took place when the Carter cost containment bills failed in the late seventies, and the Secretary decided that this is all we have to try to control health care costs, once that decision was made, the tools necessary were not provided for the program to do that job.

It was pointed out that there were a number of loopholes in this program, and indeed there were.

It was very possible to shift projects that were denied in the institutional setting into the noninstitutional setting, as mentioned several times before the committee.

I think that the central problem with the programs were—and this would be an extremely unpopular idea—because they were not regulatory enough.

If you are going to take a regulatory approach to the system, then I think you have to close the regulatory loopholes. We have left a number of them open in certificate of need.

Some States lacked the will to carry the program forward. Ultimately, the program was judged ineffective or doing something that it was not designed to do in the first place—controlling the rate of inflation in hospital costs.

This was a development program when it started out. States were interested in developing their health care systems, and you took the same folks and the same authority, and said, "Now, you are going to put a lid on the system."—very difficult to do.

Mr. PICKLE. I think you maybe correct that originally the program was sort of a distributor of resources, rather than cost containment.

Dr. KIMMEY. Correct.

Mr. PICKLE. And we have assumed that it was started for the opposite reason over the years.

So I think we have to look at other factors, and I have found your testimony interesting and helpful.

Thank you, Mr. Chairman.

Mr. DONNELLY. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. Kimmey, it was very helpful to me to hear a little bit more about the history of this system, and it explains the variation with which it has worked in my estimation even in my own State.

But, to get your opinion on some of the critical issues that Mr. Anderson raised, how do you evaluate what he calls "anticompetitive effects"?

It is true that the CON process has, in some instances, worked to prevent lower cost providers from getting into the system, and that often in the CON process, vested interests have a louder voice.

Once an investment has been made, sometimes the CON process itself tends to make it difficult for options to develop.

Could you give us the benefit of your experience?

Do you think this is the real problem? Have you seen it happen? On what scale has it happened? If we have a CON process, how

should we write that process so that we can prevent some of the anticompetitive impacts that the former process has supported?

Dr. KIMMEY. The CON process is a political process. It can be characterized as being technical and quasi-judicial and a lot of other things, but it is basically a political process.

You are putting people together, as the system was structured before, in private nonprofit governmental bodies, if I can use those conflicting terms, where you had representation from a community reviewing projects, determining need, and providing recommendations to a State agency which then would make decisions on specific projects.

Now, we all know that at various points in times, States are more or less enthusiastic about enforcing programs like this.

When I was directing the program in Wisconsin, the Governor was very much behind this kind of activity, and we were involved in extensive reviews. At the same time, the Department of Business Development was going out and saying to communities, "The best thing you could is build a nursing home. It would bring jobs, and it would bring people to your community."

These were two State policies that were directly contradictory to one another.

At that point, from the standpoint of need for nursing home beds, we did not need them. From the standpoint of economic development, we did.

I give that as one example of the kind of conflicts that arose in this process. You multiply that by 50 jurisdictions, and you can see the difficulties you have of tracing this kind of program and saying, "Here are the factors that made a difference, or did not make a difference in whether the program was effective."

I think it would be very difficult to put into place all of the strictures that one would need to guarantee this kind of approach at work.

But I think the values of the approach are—one, it gets the community involved through the planning and review process in making decisions about its own health future. I do not believe that we are in a position at this point, that the market can make those decisions.

Second, it provides an oversight mechanism for tracking the investment decisions within the field, and an opportunity to identify areas in which institutions may be investing their capital that are not necessarily the areas of greatest need within the community.

I just cannot believe that there is a community need for one more obesity center in a hospital, or one more cosmetic surgery center in the hospital.

Indeed, the need is for primary care. The need is for care for the indigent. The need is for the money to go to the public institutions.

I think that the kind of cap that you all are proposing is one way of forcing those kinds of decisions to be made—allocative decisions.

We have never had that in this program, and if, indeed, you are going to go this regulatory route, then I believe using the cap for allocative decisions is one way of giving it the rigor that the political process is sometimes not willing to give it.

Mrs. JOHNSON. Thank you very much.

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Mr. Anderson, would you like to enlarge on that issue of anti-competitiveness, and particularly as it prevents change in the structure of the health care service system?

Mr. ANDERSON. Well, I am not sure that I have any antidotes or examples to provide you with, though I do recall reading somewhere about the growth of ambulatory surgical centers.

I believe it was in the State of Pennsylvania where apparently there was a substantial delay, 6 months at a minimum, during which the State regulatory body said, "Hey, we do not know how many of these are needed, so let us not permit any until we figure it out."

So, there is one case in which you do get that kind of delay. It is always difficult to sort of show the counterfactual, show that you would have had this entry were it not for the regulation.

Mrs. JOHNSON. And how do the three studies that you say all support the fact that the CON process can have anticompetitive effects, what data do they cite?

Mr. ANDERSON. I believe the three studies that I am talking about—the three Commission studies or studies by the staff of the Bureau of Economics—actually have looked at the issue of cost control.

What has been attempted there is to look at whether costs are lower or higher——

Mrs. JOHNSON. Thank you. That is clear. So they did not really address the other issue in detail.

Mr. ANDERSON. Yes.

Mrs. JOHNSON. Thank you very much.

Thank you, Mr. Chairman.

Mr. DONNELLY. Mr. Moody.

Mr. MOODY. Thank you, Mr. Chairman.

Mr. Anderson, I guess the key part of your testimony goes to the question of capital cost and whether the CON is effective in reducing costs. Is that fair to say?

Mr. ANDERSON. Yes, I think so.

Mr. MOODY. Without getting into some of the other issues, I assume you base your conclusions predominantly on studies that you cite—three studies done by the Commission's Bureau or Economics?

Mr. ANDERSON. Those studies and the 13 other studies that I am aware of that——

Mr. MOODY. Were those three studies done by the Commission's Bureau? Were they done by Daniel Sherman?

Mr. ANDERSON. One was done by Dan Sherman, one was done by Monica Nether, the third was done by Mr. David Cass and myself.

Mr. MOODY. Right. Are those three studies, as I know most of the other 13 are, cross-sectional or are they longitudinal?

Mr. ANDERSON. They are cross-sectional studies.

Mr. MOODY. All three of them are?

Mr. ANDERSON. I believe so, yes.

Mr. MOODY. The reason I mention that is that there are obviously important econometric methodological issues involved here as to the validity of the outcome.

When you have a longitudinal study, if you look at the same institutions to develop those same background variables applying,

and you can look at them before and after CON, you can avoid a lot of the control problems that you have when you compare, at the same point in time, a cross-section of different institutions, different States, different regulatory environments and a lot of other different things going on.

I would be interested in knowing if you had a chance to look at the Julie Ann Howell study, which she did for a Harvard doctoral dissertation, which was a time series, in which she used the dummy-variable for p[illegible]imposed CON implementation on Massachusetts hospitals.

In that study she finds, in fact, that CON had a significant impact on the left-hand variable on cost.

Obviously, cross-sectional studies are very vulnerable to the omitted variable problem, policy variables, that will differ from one State to another.

Another issue that occurs to me, is that I think the Sherman study had two right-hand variables that are obviously multicollinear and they are likely to be in their effect.

Did you have the 1122 as a right hand variable?

Mr. ANDERSON. Yes.

Mr. MOODY. So all States had either 1122 or C of N during this period, right?

Mr. ANDERSON. I think that is correct, yes.

Mr. MOODY. The CON might have been a slack variable for some of those institutions.

If 1122 was the binding variable, the C of N might have had relatively little import. That is not to say that CON without 1122 would not have been important.

Finally, my understanding is that the right-hand variable in those studies are both CON and 1122 are step-wise functions—that is, that you have used the threshold approach.

So, they are neither dummy variables nor continuous variables. They are step-wise functions. Is that true?

Mr. ANDERSON. Which study are you referring to?

Mr. MOODY. Let us take the Sherman study.

Mr. ANDERSON. I believe in the Sherman study, he used the threshold level, so that would be a continuous variable.

Mr. MOODY. Not really. The thresholds go up in steps, do they not? Different——

Mr. ANDERSON. Different States have different thresholds. Exactly. So you might have one State with a threshold of 100 and another of 200 and another of 300——

Mr. MOODY. That is not a continuous variable. That is a step-wise variable. That is not a continuous variable.

Mr. ANDERSON. I would interpret it as a continuous variable.

Mr. MOODY. No, I am sorry. It is not mathematically.

You cannot have those kinds of steps and call it a continuous variable. It can be any real number or any integer, that is a continuous variable.

But if it jumps from 100 to 200 to 300, it is not a continuous variable. That is mathematically a very different kind of an animal.

Mr. ANDERSON. The question is whether you, in fact, have observations at every value—which you obviously do not, which in any

study you do not—or whether the variable is defined in such a way that it can only take on certain discrete values.

Mr. MOODY. You could not have. You cannot have.

Mr. ANDERSON. No, you could. You could. Excuse me. Why could not a State put in a limit at 110? Or 105?

Mr. MOODY. No, but States did not do that. States confine themselves to a very small set of numbers that they applied as right-hand variables for a threshold.

Mr. ANDERSON. I am sorry. I forgot to bring the study with me, but I do not remember that it is that small actually.

Mr. MOODY. The mathematical properties of that econometrically are that it dumps a lot of the explanatory zip into the airacterm, and it enlarges your air—when you have that kind of variable in the right-hand, it enlarges your airacterm and reduces the explanatory power put into the different coefficients.

Finally, it is not a very good measure of stringency. You might have a very high number, a high threshold.

I am saying that threshold is not a very good measure of stringency.

You might have a very high threshold and have a weak or strong application of that threshold, or you might have a very low threshold and have a weak or strong application of that threshold.

As Mr. Kimmey points out, it is very often a political process.

I know in Wisconsin, where Mr. Kimmey—it is very much a political process, and some States are very stringent within whatever threshold you might pick, and some States are not very stringent.

For Wisconsin, my judgment is that the way that it was, in fact, carried out, whatever your threshold, it was not very stringent. It was very political.

I am questioning the validity of using the threshold as any meaningful measure of stringency.

I have given you five or six econometric problems that I think seem to characterize the Sherman study. You may not be prepared to answer them all now, but maybe your written response would be helpful.

Do you want to answer any one of those in particular?

Mr. ANDERSON. Certainly, the threshold is not a perfect measure. I will grant you that.

Mr. MOODY. You say it is not?

Mr. ANDERSON. Is not a perfect measure.

I am not aware of any perfect measures that exist. States will differ within their limits. It still seems to me that threshold probably tells us something about stringency, and it is probably a good measure to use in a study of this kind.

Mr. MOODY. It may be. Let me just interrupt for a second.

You know that the Sherman study had statistically insignificant T-statistics on those two variables.

So it means you could not say one thing about them or one thing or another about them. But not only were they below two, they were below one, which just shows that it is out of the ball park.

Mr. ANDERSON. But I believe that what Dr. Sherman says in his study is that part of the reason for that is that he is measuring CON stringency in a number of different ways. He is looking at capital expenditures thresholds, he is looking at new service review

thresholds, he is looking at operating equipment—capital equipment thresholds, and these three measures all tend to move together. States that have high levels in one tend to have high levels in another.

So we have got what econometricians refer to as multicollinearity among those variables.

Mr. MOODY. So I brought it up——

Mr. ANDERSON. The way to deal with that, or one way to deal with that which he does in his study, is to ask, "Well, if all of these moved together, I cannot really separate out the separate affects, but I can say something about the combined affect."

Mr. MOODY. Did he apply a CHOW test?

Mr. ANDERSON. I do not know whether he did a CHOW test or an F test on the three coefficients together. I think it was an F test, and he found that the three moving together was significant.

Mr. MOODY. Right. So it did have an impact on cost?

Mr. ANDERSON. Yeah.

Mr. MOODY. Taken together?

Mr. ANDERSON. Taken together.

Mr. MOODY. That was my earlier point that one might be a slack variable while one is a binding variable in a given State.

Mr. ANDERSON. But moving together he found that the higher the threshold, the lower the cost.

Mr. MOODY. Yeah, right.

Mr. ANDERSON. Right.

Mr. MOODY. That is OK. I have no problem with that.

I am just saying that the value of the coefficient, the numeric result, is going to be affected by the fact that you do not have a right-hand continuous variable. That is a technical sketch, and we can follow it another time.

But I am happy to hear, in fact, that taken together, using a CHOW test, they do have some statistical significance.

That is very important, and I assume the direction was in the expected direction, namely, they tend to restrain costs.

Mr. ANDERSON. No, Congressman, they——

Mr. MOODY. In other words, taken together, they actually increase costs.

Mr. ANDERSON. Yes.

If I could jump back to your first point, the question about the Howell study, I have not read her dissertation. I have seen a piece that was published somewhere, and I cannot remember exactly where.

But the lesson that I took from that piece was that, indeed, it was very difficult to do longitudinal studies, perhaps more difficult to do longitudinal studies than to do cross-section studies, because things other than the regulation will change during the time period as we go from regulated to nonregulated.

Mr. MOODY. Sure.

Mr. ANDERSON. And she found—she was looking, as I recall, at investment in beds rather than in costs, and I think the problem is greater there.

But she pointed out that you saw lots of hospitals in one period of time adding lots of beds, presumably because of technological

change that had occurred, and at another point in time, you did not.

So if you had, let us say, put the regulation on just after this boom in bed construction had occurred, you would have a great risk of saying that the regulation had reduced beds, when in fact, all you can do is say, "Well, what does it look like from X to Y, and from then on?" You have no way to separate out whether it is a change that would have occurred anyway, or a change due to the regulation.

Mr. MOODY. OK. Well, we could argue the value of the two studies.

I would argue that if you take a set cohort, like a Massachusetts cohort as she did, and looked before and after, and if you have other right-hand variables to control for those factors you just described, you are better off than spanning across 50 different States, or you would have an enormous number of tremendously important omitted variables.

Mr. ANDERSON. I would suggest that both of them have series problems.

[The following was subsequently received:]

FEDERAL TRADE COMMISSION
Washington, D.C. 20580

BUREAU OF ECONOMICS

March 23, 1989

The Honorable Jim Moody
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Moody:

During my testimony before the Subcommittee on March 13, 1989, you suggested that there was an inconsistency between my claim that the economic evidence suggests Certificate of Need (CON) regulation has not successfully reduced the costs of health care and the claim that CON poses a barrier to new entry into health care markets. In response to your request for additional information on this point, I would like to expand on the discussion at the hearing and to attempt to demonstrate that there is no inconsistency between these two lines of thought.[1] Much of the discussion in this letter is drawn from the Federal Trade Commission's decision in the Matter of Hospital Corporation of America (106 F.T.C. 361 (1986)). Copies of that decision and of the decision of the Commission in American Medical International, et al., (104 F.T.C. 1 (1984)) are attached to this letter.

Before discussing the apparent inconsistency, it will be useful to clarify what I mean by a barrier to entry. When I refer to a government regulation as creating a barrier to entry, I mean that the regulation imposes a cost on a firm wishing to begin offering a good or service that permits incumbent firms to charge prices that exceed those that are socially optimal without attracting additional entry. To simplify slightly in order to capture the essential concept involved, a governmental regulation can be thought of as posing a barrier to entry if the regulation inhibits entry of new firms and thereby allows existing firms to charge prices that exceed the social costs of providing that good or service.[2] Absent the regulatory impediment, new firms would be attracted to the market and competition among the new and incumbent firms would result in prices being driven down to the level of costs.[3]

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[1] This response, like other answers to questions posed at the time of the testimony, represents my own views and not necessarily those of the Federal Trade Commission or any of its members.

[2] I focus on the social costs of providing a good or service rather than the private costs, because a regulatory barrier may increase the private costs of providing services and therefore mean that providers are not earning super-normal profits. For example, if taxicab drivers are required to purchase one of a limited number of medallions before they can operate a taxi in a city, there is a barrier to entry in the sense that the number of taxis is limited and the price of a ride in a taxi would be expected to be higher than if free entry was permitted. However, the cab operator is not earning super-normal profits because his costs include the costs of purchasing and holding a medallion. The costs of owning the medallion are a private cost but not a social cost.

[3] Economists and antitrust practitioners frequently define a barrier to entry as an impediment to new competition that would cause a new firm beginning operation in an industry to incur higher costs than those borne by existing producers. While some governmental regulations that would satisfy my definition of a barrier would not satisfy this definition, this distinction does not appear to be present in the case of Certificate of Need. As the Federal Trade Commission noted in its decision in Hospital Corporation of

(continued...)

As the Federal Trade Commission noted in Hospital Corporation of America, there are two ways in which Certificate of Need regulation could pose a barrier to entry into hospital markets. First, even if a firm desiring to build a new hospital is ultimately able to obtain regulatory approval, the CON process can increase the cost of new entry because of the costs and delays involved in obtaining CON approval. Second, it is not clear that a new entrant can obtain approval to construct a new hospital.[4]

In its discussion of CON as a barrier to entry, the Commission focused on the need for a new hospital to obtain regulatory approval to construct new beds.[5] Obviously, if a new hospital cannot obtain approval to build beds, it cannot operate as a hospital. Thus, the key question is whether CON regulation actually limits or retards the construction of new hospital beds.

As I mentioned in my testimony, some of the studies examining the effectiveness of CON regulation have found some reduction in hospital beds where there is CON regulation.[6] Thus, there is some support for the hypothesis that CON regulation creates a barrier to entry by denying approvals to build new hospitals.

Of course, I also noted that the economic studies have overwhelmingly found that CON regulation has not been successful in reducing health care costs. It may initially appear that there is an inconsistency between this conclusion and the finding that CON regulation may have limited the construction of new hospital beds. However, this apparent inconsistency can be resolved by realizing that hospitals can improve their apparent quality, and in the process increase their costs, in more than one way. As I noted in my testimony before the North Carolina State Goals and Policy Board, when faced with CON restrictions,

> hospitals were able, the evidence suggests, to find new ways to compete. For example, if the CON law only required approval for some kinds of capital investments -- *e.g.*, new beds -- the hospitals could add other kinds of fancy equipment. If all equipment was covered, hospitals could compete by providing additional staff. Thus, CON regulation did not lower costs by ending supposedly unnecessary expenditures, it merely redirected such expenditures into other areas.[7]

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[3](...continued)
America, since CON regulations date from the mid-1960s or later, many incumbent hospitals were in existence prior to the enactment of CON regulation and therefore never had to incur the costs of obtaining CON approval to enter the hospital industry. (See Hospital Corporation of America, 106 F.T.C. 361 at 491.) (The problem with traditional definitions of barriers to entry in the context of governmental entry restrictions is noted by Harold Demsetz. See "Barriers to Entry," *American Economic Review*, 72 (March 1972), p. 48.)

[4] See Hospital Corporation of America, at 491-494.

[5] Hospital Corporation of America, at 491, n. 22.

[6] In particular see, David S. Salkever and T.W. Bice (1976), "The Impact of Certificate of Need Controls on Hospital Investment," *Milbank Memorial Fund Quarterly*, 54 (Spring), pp. 185-214, and Paul L. Joskow (1980), "The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital," *The Bell Journal of Economics*, 11 (Autumn), pp. 421-447. (I enclose copies of these studies.) On the other hand, Sloan and Steinwald found that the only significant effect of CON regulation on the number of hospital beds was an increase in the number of beds in the year before CON regulation became effective. (Frank A. Sloan and Bruce Steinwald (1980), "Effects of Regulation on Hospital Costs and Input Use," *Journal of Law and Economics*, 23 (April), p. 102. I also enclose a copy of this study.) Such an "anticipatory" expansion of bed supply is only rational if it is expected that CON regulation will pose a barrier to construction of new beds after regulation is imposed. (On this point, see Hospital Corporation of America, at 494.)

[7] "Certificate of Need Regulation of Health Care Facilities," Prepared Statement of Keith B. Anderson, Special Assistant to the Director, Bureau of Economics, Federal Trade Commission, Before North Carolina State Goals and Policy Board, March 6, 1989, p. 7 (footnote omitted).

The evidence on this point comes primarily from two of the earlier studies of the effect of CON regulation. Salkever and Bice found that while Certificate of Need regulation was associated with a lower rate of growth in hospital beds, it was not associated with a lower growth rate for total assets.[8] This finding suggests that hospitals were adding other assets when their efforts to increase beds were foreclosed. Evidence of substitution toward noncapital inputs were found by Sloan and Steinwald who found that hospitals subject to CON regulation tended to have higher employment levels than comparable unregulated hospitals.[9]

Additional evidence consistent with the notion that hospitals substitute nonregulated for regulated inputs is found in the Sherman study. Sherman finds that if CON regulation is relaxed by raising the thresholds for reviewing capital expenditures, new services, and equipment purchases by 10 percent each, hospital costs, net of capital costs, decrease by a statistically significant 0.2 percent. However, when capital costs are included, he finds the decrease in costs associated with a loosening of CON regulations is not statistically different from zero.[10]

In sum, CON regulation may create barriers to entry by making it difficult to obtain regulatory approval to construct a new hospital.[11] At the same time, incumbent providers may be able to avoid any cost constraining effects by redirecting their expenditures into unregulated areas.[12] Thus, the finding that CON has been ineffective in controlling costs is not inconsistent with the claim that CON regulation may create a barrier to entry.

I hope that this information will be useful to you and to the Committee in its deliberations on H.R. 712. If I may be of further assistance, please let me know.

Sincerely,

Keith B. Anderson
Special Assistant to the Director

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[8] Salkever and Bice (1976).

[9] Sloan and Steinwald (1980).

[10] Daniel Sherman, *The Effect of State Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis*, Bureau of Economics, Federal Trade Commission, January 1988, p. 60. (A copy of this study is enclosed.) I would also correct a slight misstatement made during my testimony on March 13. In discussing the presence of multicollinearity among the various regulatory variables in the Sherman study, you asked whether Sherman had run a Chow test in evaluating the combined significance of the different threshold variables. While I responded at the time that I believed he had run an F-test, I now find that I was incorrect. The hypothesis Sherman wanted to test was whether an equal percentage increase in each of the three thresholds was associated with a significant change in costs. Since the threshold variables are included in his regression equations in logarithmic form, the effect of a one percent increase in each of the three thresholds is merely the sum of the three coefficients. The significance of the sum of coefficients can be tested with a t-test with the sum of the coefficients in the numerator and the square root of the variance of the sum, including the appropriate covariance terms, in the denominator. This appears to be the test Sherman used. (Sherman, p. 60, n. 90)

[11] CON regulation may also pose a barrier to the entry of existing hospitals into the provision of new services if the regulatory process makes it more difficult for providers to obtain approval to offer new services.

[12] Another possibility is that incumbent providers may be able to obtain approval for the projects they wish to undertake, while new entrants are unable to obtain approval. (This possibility, and the possibility that incumbent hospitals would attempt to assure this result by supporting each other's applications for new projects while jointly opposing applications from new entrants is discussed in the Commission's opinion in Hospital Corporation of America, at 497-498.)

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Mr. DONNELLY. The gentleman's time has expired.

The Chair would be glad to yield his time to my friend from Wisconsin after the members have an opportunity on the first round of questioning.

Mr. Anthony.

Mr. ANTHONY. No questions.

Mr. DONNELLY. Mr. Levin.

Mr. LEVIN. As I listen to your testimony, Mr. Anderson, it is hard for me to know whether we are arguing kind of labels and theory or reality.

You indicate the market is likely to work better, so essentially let us keep our hands off.

As I read the paragraph on page 7, "as consumers and health insurers become more cost-conscious, hospitals with inflated costs and prices will increasingly risk losing business"—and there is a reference to HMOs and PPOs.

"That the growing cost sensitivity of consumers and health insurance should increase incentives for hospitals to provide quality service at the lowest possible price."

And yet, what the administration does is to come into these halls and say, "cut-off 25 percent," which in a sense, is the most stringent interference with the market that one can imagine.

I do not see how those two things hold together. It seems to me, instead of going from 15 to 25 percent, the administration ought to be coming in here and saying, "There is growing sensitivity by consumers and insurers. The market is going to work better. There are more incentives."

Let us have less Government interference, and instead of 15 percent, reduce it to 10 and then 5.

Mr. ANDERSON. Congressman, as I said in my statement, at this point I am only speaking for myself, not even for the Federal Trade Commission, let alone the administration.

But I think the only way that I can respond to you is to note that in some sense here, when we are talking about Medicare, which is after all, the subject of the hearing today, we really are talking about the Government acting as an insurer.

One way to interpret what the administration is saying is that they think they can—but as an insurer, that is a proper function for them.

Mr. LEVIN. Well, if it is a proper function to approach that way, I assume it is then proper for an insurer to look at need.

Mr. ANDERSON. As an insurer—if the government is acting as an insurer, I cannot say it is improper.

Mr. LEVIN. So——

Mr. ANDERSON. As a matter of fact, I do not think I would portray it as improper.

I think what my statement attempts to discuss is the experience we have with CON. I suggested that CON—which went beyond the government as insurer, because it covered facilities that were going to be paid by third-party payers and by private individuals—has not worked.

Mr. LEVIN. Almost all of the facilities impact on Medicare. So for you to say that it went beyond, you cannot slice these into neat packages, right?

These facilities are multipurpose facilities. They relate to Medicare patients as well as others, so I do not think you can say that the trouble with it is that it went way beyond.

In a sense, what we did was to take the role of the insurer, the Federal Government, and apply the principal federalism, and say that we will not do it in Washington, we will do it in the States.

So, it seems to me, conceptually within your framework, there is no quarrel with the certificate of need. It is just that it has not, you say "worked."

You do not quarrel with it ideologically, or conceptually, then you are saying that you do not like it just because it does not work.

Mr. ANDERSON. Well, I think I have concerns about it.

The possibility that it increases costs, because it limits entry and creates anticompetitive problems. The fact that it has not been effective in reducing costs.

But, no—it certainly is not, it seems to me, inappropriate for an insurer, be they the Government or be they a private insurer, to attempt to control the costs that they have to pay for.

Mr. LEVIN. A 25-percent swath surely can inhibit competition? Right?

I mean, just conceptually, it can have a terrible effect on competition, no?

Mr. ANDERSON. I suppose if a new firm knows that they are going to get reimbursed at 25-percent less than they—you know, if the firm is thinking about entering this year, and the payment level is 25 percent lower than last year, they are probably less likely to enter this year than last year.

Mr. LEVIN. And if they know it might be 35 percent the following year, they do not even know what it would be the following year.

So it seems to me your critique about delling competition, et cetera, it is maybe, especially applicable to what the administration is proposing.

I think this, therefore, takes us back to Mr. Pickle's question. It is one thing to engage in these critiques. It is another to come up with an answer.

I truly think the most anticompetitive answer I can think of is cutting it across the board "willy-nilly" at 25 percent.

I would hope you might join in to come up with other conclusions.

Thank you very much.

Mr. DONNELLY. Mr. Moody.

Mr. MOODY. Thank you, Mr. Chairman.

I won't prolong our technical discussion about econometric modeling, but let me just ask you one brief question, and then I want to get into a more policy question.

Is the presence of rate review, which Wisconsin had along with CON, one of the right-hand variables of the Sherman study?

Mr. ANDERSON. We're checking, Congressman. I don't believe he did include rate review.

Mr. MOODY. All right, that goes back to my earlier——

Mr. ANDERSON. I'm sorry. Yes, he did. He did.

Mr. MOODY. OK. He did. That's obviously another collinear variable. States, at least in my experience, that tend to have rate review tend to have more strict CON philosophy.

Mr. ANDERSON. I don't know whether that's true or not.

Mr. MOODY. Anyway, getting away from the methodological questions, you say that the CON tends to be anticompetitive. So, it has been a barrier to entry, in your judgment.

You don't base that on a study, that's just an opinion, right?

Mr. ANDERSON. The Federal Trade Commission has said that in a couple of hospital cases. Judge Posner, out in the Seventh Circuit, I think, has upheld the Commission on that and directly touched on that issue and agreed with the Commission on that.

Mr. MOODY. But you don't have a study of econometrics to say that nationwide it has been a significant barrier to entry, do you?

In Wisconsin, it wasn't a significant barrier to entry; it was just a political process, and everyone eventually got what they wanted, virtually. It was not a significant barrier to entry, in my observation. Dr. Kimmey can correct me.

Would you correct me?

Dr. KIMMEY. No, I agree.

Mr. MOODY. It was not a barrier to entry in my State, so when you say it is a barrier to entry, what are you basing that on?

Mr. ANDERSON. I'm reporting to you the analysis of the Federal Trade Commission in their cases.

Mr. MOODY. OK. So, it may or may not be a barrier to entry, so obviously it depends tremendously on how it is implemented State by State. In my experience, it was not a barrier to entry.

Looking at your first two points in a combined sense, it is not effective in reducing total costs, and total costs have capital costs and operating costs, right?

It is not effective in reducing total costs, but it is effective, according to you, in being a barrier to entry, which means reducing capital costs.

Are you therefore saying that those two conclusions taken together, imply that there has been a substitution of operating costs for capital costs?

Since total costs are dampened, and since it's a barrier the capital structures are inhibited, has it caused an increase in operating costs?

Mr. ANDERSON. I'm not sure that the presence or absence of it as a barrier necessarily implies any impact on capital costs. It may well be that what's happened is that new entrants have not been able to get approval, but approvals have gone to incumbent firms who then have more capital than they would otherwise.

Mr. MOODY. Oh, I see, by barrier entry, you mean whole new hospitals springing in?

Mr. ANDERSON. Whole new hospitals, yes.

Mr. MOODY. I see.

Mr. ANDERSON. Or, possibly hospitals wanting to add services where they would compete with existing providers. You know, you may have two existing hospitals, hospital A wants to enter, to provide a service that hospital B currently is providing. They may not be able to get approval for that.

Mr. MOODY. Well, this puts a whole new light on it, because if what you're saying is that the existing hospital has been able to expand—if you say, it has not reduced capital costs but it has been

a barrier to entry to new hospitals, but then it hasn't been a barrier to existing hospitals, apparently.

If that's the case, it seems to me that you might make an argument that it has enhanced competition, because hospital A wants to open a wing to compete with hospital B on something that only hospital B has at the moment, in this community.

It seems to me that in that sense that it might enhance competition.

Mr. ANDERSON. But that's what they have not been able to do.

I mean if it has been functioning as a barrier to entry, what I mean by that is that hospital A has not been able to open a wing to compete with hospital B; or hospital C, who is not in the market at all, has not been able to build a hospital to compete with A.

Mr. MOODY. But if it's the second, that is, hospital A that exists can't open a wing, then how do you square that with your statement that it hasn't reduced capital costs because it hasn't permitted new hospitals to open up?

I mean that was your first response.

Mr. ANDERSON. No, my response is——

Mr. MOODY. I mean if hospital A has not been able to build a wing and hospital C has not been able to get in the ballgame at all, then presumably capital costs are reduced?

Mr. ANDERSON. Unless hospital B has built a larger capacity unit than they would otherwise have.

Mr. MOODY. To compete with whom? If they have no competition——

Mr. ANDERSON. To provide the service that is needed by the community.

Mr. MOODY. That's not otherwise being provided already somewhere?

If it is not otherwise being provided, it is not anticompetitive to have them come in. Anticompetitive implies that one person is doing it, and now we are not going to let others do it.

But if you are opening a whole new wing for a whole new service, that's not a competitive issue, is it? It's an access issue.

Mr. ANDERSON. Well, I think it is.

Mr. MOODY. I guess I'll go back to my basic question: Does CON in your analysis reduce capital costs? Or not?

Mr. ANDERSON. The evidence contained in the studies suggests no, that it doesn't.

Mr. MOODY. And yet it is a barrier to capital costs being undertaken?

Mr. ANDERSON. It is a barrier to entry by new firms, yes.

Mr. MOODY. Or by an enlargement of existing firms?

Mr. ANDERSON. Or by expansion of services by firms not currently providing those services, yes.

Mr. MOODY. OK. Well, that data, the specifics beyond these opinions that I don't see substantiated in the report, I would be most anxious to read, and maybe you could send me some to back up those points, because there is a potential conflict or tension between those two points. But it could be resolved if you could show me how.

But do you see my point, my question?

Mr. ANDERSON. Ah——

Mr. MOODY. That if it is a barrier to capital, and yet it doesn't reduce total costs, then somehow operating costs must have gone up?

If capital costs are restrained, the total costs are not restrained, then somehow operating costs have gone up?

Do you see the point?

Mr. ANDERSON. I think I see your point, yes.

Mr. MOODY. OK, thank you.

Thank you, Mr. Chairman, for the time—the extra time.

Mr. DONNELLY. Thank you.

Dr. Kimmey, you haven't had much opportunity to participate. Do you have a final statement to make to the committee?

Dr. KIMMEY. No, I think it has been a very interesting discussion.

You raised some questions about the econometric aspects of the Sherman study. I would have raised some of the same, and would have some others.

So, I go back to my original point: It's not so much whether these studies are elegant and reproducible as it is what's happening in the health care field right now. What's happening is that the capital investment is unrestrained by either the market or regulation, and it's creating problems.

That is the problem the committee needs to deal with.

Mr. DONNELLY. Gentlemen, thank you.

The next panel will include Jack Owen from the American Hospital Association; Dr. William Waters, president-elect of the American Health Planning Association and the associate director of the Department of Health in the State of Rhode Island; and Dan Sisto, who is the president of the Hospital Association of New York State.

If we could begin with Mr. Sisto——

Mr. SISTO. Thank you, Mr. Chairman.

Mr. DONNELLY. And proceed by the order that you are listed on the program.

STATEMENT OF DANIEL SISTO, PRESIDENT, HOSPITAL ASSOCIATION OF NEW YORK STATE

Mr. SISTO. On behalf of the hospitals in New York State, I thank you for the opportunity to testify and to present our views of the Capital Expenditure Amendments of 1989.

The Hospital Association of New York State is comprised exclusively of not-for-profit hospitals that bring a strong sense of social mission to their view of these issues. I do not believe that the health care system is simply another business; and, while the health care system is an important part of our economy, it is unlike other sectors of that economy.

We believe that health care is a community affair where the public has a right to a forum and to debate capital investment decisions supported by their own money.

When the public makes an investment in a hospital, it needs to look at more than the monetary return on the investment. The return to the community comes in the form of needed health care services, social services, and training new health care professionals.

We do not seek to justify an overabundance of hospital beds; we don't believe that we should build hospital beds on speculation or on the hope that they may be filled sometime in the future.

If we continue to build excess hospital capacity, we will soon be unable to support existing needed capacity. We believe that the Medicare program and all other third-party payers have an obligation to adequately reimburse hospitals for needed operating and capital expenditures, once they have been identified as needed.

On the issue of regulation and competition, we really come here today to say that we are in the middle between these two extremes. In New York State, we are receiving the worst of both worlds.

Incorporating capital into the PPS rate typifies the free market health care strategy. The theory behind this approach would have us believe that hospitals that are competitive and efficient will survive, and those that are not will perish.

The approach overlooks the realities of the health care system.

Hospitals that have recently made or are about to make capital investments would be severely underpaid. Hospitals with plants in the middle of their life cycle could receive a windfall.

The approach assumes that all hospitals have equal access to the capital market. Nationwide, inner-city hospitals and small rural hospitals are seen as risky investments, and when these hospitals go to the capital market, they must assume higher interest rates.

On the other side of the coin, the regulatory side, in New York State has a highly centralized planning system that seems unable to respond to changes in the environment.

While national occupancy levels hover around 60 percent, in 1988, New York's total average occupancy rate is estimated at 83 percent, and was rising rapidly as the year neared end.

The occupancy level in some urban hospitals regularly exceeds 100 percent. Elective admissions are routinely postponed. The majority of admissions in New York hospitals are now through the emergency room.

Overregulation and neglect have taken their toll on New York's hospital system. Once known as the world leader in terms of its hospitals, research, education, and development of treatment, New York is now becoming a place where dwindling resources and increased expectations are compromising both its high standards for quality as well as basic access to care.

The problems confronting the system and contributing to its instability are both social and financial. Among the predominantly social problems are: a growing AIDS population; serious societal issues, such as homelessness, drug abuse, and mental illness; increasing numbers of uninsured and underinsured New Yorkers who must be cared for despite their inability to pay.

Financial problems include: historical underfunding which threatens our very viability; serious shortages of health care personnel; a lack of inpatient beds leading to medical gridlock; a lack of nursing home and home health care services at a time when the population is becoming preponderantly more elderly.

According to AHA, in 1986, the average overall bottom line margin of a hospital in the United States was 5.31 percent. For New York hospitals, it was a negative 1.89 percent.

This year hospitals in the State will again have negative bottom lines. We are unable to increase our charges to Blue Cross or private paying patients to make up reductions in Medicare payments. And yet our ancillary service markup in New York is 1.05 percent, compared to a national of 1.66.

In spite of our poor financial showing, we believe that New York hospitals are still among the most efficient in the country. They have the highest occupancy in the nation, one of the lowest staff-to-patient ratios, and we have been able to contain health care costs.

Since 1978, the year-to-year increase in the cost per discharge nationwide has been 10.4 percent compared to 8.1 percent in New York. In other words, hospital costs in New York increased 25 percent less than hospital costs nationwide.

In general, then, we are caught in a dilemma. When I say we are getting the worst of both worlds, we are subjected to a congressional reaction to underutilization that calls for 15 and now 25 percent across-the-board cuts in capital; and, at the same time, subject to a State system that puts us through a rigorous certificate of need process and rigorous health planning.

In general, we would support rational local health planning and the efficient development of health care services and full reimbursement for needed hospital capital expenditures.

This year, the reduction in Medicare capital payments for Medicare alone will cost New York State $60 million; and if you move to 25 percent, that cut will cost New York State hospitals $100 million. We simply cannot make up that loss.

We believe that hospitals in any State which has a health planning system that meets appropriate criteria and that is effective in attaining specified occupancy goals, or is making specific progress toward these goals should receive an exemption from any reduction or limit in capital payments.

As for local health planning, we believe that local and regional health planning is a prerequisite to good statewide health planning, and that any new health planning system should, at a minimum, incorporate the following principles:

Retention of health planning on a local and regional basis.

Independent, credible, and objective planning—that is, bottom-up planning, not top-down implementation of compulsory planning guidelines.

Local planning agency funding that is not controlled by a central administrative State planning agency, or administrative agency.

And a broadening of the governance structure of local planning agencies to include major constituency groups in the area.

As to occupancy standards, I believe the occupancy standards proposed by H.R. 712 are unreasonably high and may lead to nationwide medical gridlock.

The demand for hospital services, like the demand for electricity, fluctuates. We know from New York State's experience that, if we construct hospitals for an average occupancy of 85 percent, there will be many times when the hospitals will be more than 100 percent filled.

When hospitals are filled to capacity, patients may not receive the quality of care they are entitled to, or even be admitted.

As for capital expenditure limits, we are also concerned about the proposal. Based on our experience in New York, we would oppose this limit. A similar approach was suggested in our State several years ago, and was finally rejected by the legislature because of the complexity of administering the program.

For example, how would an expenditure limit address unforeseen changes in the health care environment, such as the AIDS epidemic now rampant in New York State?

H.R. 712 would provide an annual increase in capital expenditure limit based on changes in Medicare admissions and changes in the cost of construction. This adjustment would not effectively reflect changes in the cost of construction or in the cost of equipment resulting from changes in medical technology.

Our conclusion is then that there is nothing inherently wrong with the Medicare capital passthrough, especially when it can be linked to rational health planning. It is still the most equitable way to reimburse hospitals for needed capital expenditures.

All of the other approaches, from incorporating capital into the PPS rate to some form of capital expenditure limit, create more problems than they solve.

Thank you.

[The statement of Mr. Sisto follows:]

STATEMENT OF DANIEL SISTO, PRESIDENT
of
THE HOSPITAL ASSOCIATION OF NEW YORK

Mr. Chairman, I am Daniel Sisto, President of the Hospital Association of New York State (HANYS). On behalf of 275 hospitals in New York State, I thank you for the opportunity to present our testimony on the Medicare Inpatient Capital Expenditure Amendments of 1989.

I am here to support a more rational balance between the extremes of the pro-competition health care strategies in vogue over the last eight years and the micro-management regulatory approach so evident in New York State.

BASIC PRINCIPLES

I would like to begin by sharing with the Committee my beliefs about our health care system. First, in New York State, public officials, the health care provider community, and the public view hospitals as a vital public service, as essential to the community as the fire department or the police department.

Hospitals are as important to the infrastructure of a community as the telephone company or the electric company. Few businesses would locate in a community that lacks an adequate infrastructure--such as adequate roads, electricity or water, or an adequate hospital.

Hospitals are also an important part of our educational infrastructure. They are an essential part of the education of all health care professionals from physicians to nurses to technicians. Given the critical and growing shortage of health care professionals, we, as a nation, must support medical education.

Second, I believe that everyone in this country is entitled to adequate health care services. But like most things, health care has a cost, and someone, whether it is the public sector or the private sector, has to pay for these services.

This is a critical problem for New York State's health care system. Over 2.5 million New Yorkers have no health insurance. The vast majority are employed in low-paying jobs or are dependents of these employees. The hospital is often the only source of health care services for many of the uninsured and the cost of uncompensated hospital care in New York State is now approaching $1 billion annually. While a New York State funding program covers approximately one-third of these costs, hospitals receive no payment for the remainder.

Third, I do not believe that health care is simply another business. While the health care system is an important part of our economy, it is unlike other sectors of our economy. I believe that health care is a community affair, where everyone in the community has a right to speak and that the public has a right and a forum to debate capital investment decisions supported by their own money.

When the public makes an investment in a hospital, it needs to look at more than the monetary return on this investment. The return to the community comes in the form of needed health care services, social services, and in training new health care professionals.

Fourth, I cannot justify an overabundance of hospital beds and I don't believe we should build hospital beds on speculation or on the hope that they may be filled sometime in the future. If we continue to build excess hospital capacity, we will soon be unable to support existing needed capacity.

Fifth, I believe that the Medicare program and all other third party payors have an obligation to adequately reimburse hospitals for needed operating and capital expenditures. If we are unwilling to support our health care system, then we should explicitly ration health care services. Too often government and other third party payors hide behind complicated reimbursement formulas that disguise their real intent.

REGULATION VERSUS COMPETITION

"Regulation versus competition" has become the shorthand for health planning and certificate of need versus incorporating Medicare capital payments into the PPS rate.

A Competitive Strategy

Incorporating capital into the PPS rate typifies the "free market" health care strategy. Under this approach, every hospital receives essentially the same capital payment. The theory behind this approach would have us believe that hospitals that are competitive and efficient will survive; those that are not, perish. This simplistic approach overlooks the realities of the health care system.

Hospitals that have recently made or are about to make capital investments would be severely underpaid. Hospitals with plants in the middle of their life cycle would receive a windfall.

During the latter part of the last decade and early part of this decade, the New York State Department of Health forced hospitals in New York to postpone capital investments. In 1983, there was an explicit moratorium on all health care capital projects. However, over the last several years, hospitals in New York have begun to undertake needed renovations and modernizations. Any system that incorporates capital payments in the Medicare DRG will unfairly penalize these hospitals.

This approach also assumes that all hospitals have equal access to the capital market. Nationwide, inner city hospitals and small rural hospitals are seen as risky investments. When these hospitals go to the capital market, they must assume higher interest rates.

Many of New York's hospitals are in poor financial condition. In 1988, New York's hospitals had operating losses of approximately $350 million. Over the last two years, Moody's Investors Services and the Standard and Poor's have lowered the investment ratings of many New York hospitals. Lower investment ratings mean higher interest costs. Any capital reimbursement system that ignores the financial condition of hospitals only adds to the financial burden of these facilities.

Incorporating capital into the PPS has many technical problems. Given the problems we face with the geographic delineations for Medicare wage index and with the non-wage index, I am not sure we could develop an equitable nationwide capital cost index.

A Regulatory Strategy

Health planning and certificate of need typifies a regulatory health care strategy. Over the last several years, many states have eliminated health planning and certificate of need. In some states, health planning operates with few real standards or criteria.

New York, however, represents the opposite extreme. In New York, health planning has fallen under the yoke of bureaucratic rule. Through regulation, government has come to manage the most minute details of hospital operations. There is no true debate, no real representative forum, and the public has lost its right to debate the future of health care in their communities. Over-regulation and centralized planning stifle innovation, increase operating costs, and in some cases, threaten the quality of hospital care.

As we have seen in New York, a highly centralized planning system is unable to respond to changes in environment. New York

hospitals are now suffering from medical gridlock. While national occupancy levels hover around 60%, in 1988, New York's total average occupancy rate was 82.8%. The occupancy level in some urban hospitals regularly exceeded 100%. In many ways, it is similar to the queueing system in Great Britain. Physicians can no longer admit a patient to a hospital simply because the patient needs hospital care. Patients now go on lists until beds become available.

Elective admissions are routinely postponed. In New York, an elective admission is any admission that is not an emergency. Elective procedures, such as chemotherapy, radiation therapy, heart surgery, and pediatric care are often postponed for weeks, and in some instances, for months.

The majority of admissions to New York hospitals are now emergency admissions. In 1983, 44.4% of all admissions were unscheduled. In 1987, 51.9% were unscheduled. Preliminary data suggest that this percentage increased during 1988.

This trend has had a pronounced effect on hospital lengths of stay and the use of hospital resources. Emergency admissions are more likely to have multiple diagnoses and have a 57% longer length of stay than other patients. These patients now account for 63% of all hospital patient days in New York. Moreover, it is not uncommon for patients entering the hospital through the emergency room to spend several days in the emergency room until a bed becomes available.

THE CONDITION OF NEW YORK STATE'S HOSPITALS

Over-regulation and neglect have taken their toll on New York's hospital system. The system is crumbling. Once known as a world leader in terms of its hospitals, research, education, and development of treatment, New York State is now becoming a place where dwindling resources and increased expectation are compromising both its high standards for quality as well as basic access to care.

The problems confronting the system and contributing to its instability are both social and financial.

Among the predominantly social problems are:

- A growing AIDS population;
- Serious societal problems such as homelessness, drug abuse, and mental illness which have forced hospitals to serve as the only institution of refuge; and
- Increasing numbers of uninsured and underinsured New Yorkers who must be cared for despite their inability to pay.

There are also problems which are primarily financial, including:

- Historical underfunding which threatens the fundamental viability of hospitals;
- Serious shortages of health care personnel;
- Lack of inpatient beds which has led to "medical gridlock"; and
- A lack of nursing home beds at a time when the population is becoming preponderantly more elderly.

Some recent studies have suggested that New York's hospitals have the highest Medicare margins in the country. I do not know that New York's hospitals have this honor. However, if the movement to a full national rate were designed to benefit the most efficient hospitals, then this may be true. Unfortunately, New York's hospitals do have the honor of having the lowest operating margins and bottom line margins in the country.

According to the American Hospital Association, in 1986 the average overall bottom line margin of a hospital in the United States was 5.31%. For New York's hospitals, the bottom line margin was a negative 1.89%. In 1987, the average United States hospitals continued to have a positive bottom line margin, and hospitals in New York barely broke even. This year, hospitals in New York will again have negative bottom lines. New York's hospitals are also unable to increase their charges to Blue Cross or private paying patients to make up reductions in Medicare payments. The total ancillary service mark-up in New York is 1.05%; nationwide, it is 1.66%.

In spite of our poor financial showing, New York's hospitals are still the most efficient in the country. We have the highest occupancy in the country and one of the lowest staff-to-patient ratios. (New York has 3.58 staff per patient while nationwide, this average is 4.38.)

In addition, New York's hospitals have been able to contain costs. Since 1978, the year-to-year increase in the cost per discharge nationwide has been 10.4%, compared to 8.1% in New York State.

It would be inappropriate to penalize hospitals for being efficient and well-run.

THE MEDICARE INPATIENT HOSPITAL CAPITAL EXPENDITURES ACT OF 1989 - HR-712

In general, we would support rational local health planning and the efficient development of health care services and full reimbursement for needed hospital capital expenditures.

Full Reimbursement for Needed Capital Costs

I began by stating that hospitals are an important part of the community. They are an essential part of the infrastructure. In most states, when the electric company develops needed capacity, they are assured adequate revenue to cover their capital costs. This is part of the implied social contract governing utilities and other community services.

The present reductions in Medicare payments for capital costs are, in many ways, a breach of this contract. In New York, hospitals have developed needed capacity, yet the Medicare program fails to recognize these costs. This year, the reduction in Medicare capital payments will cost New York's hospitals over $60 million. If Congress increases the size of this reduction from 15% to 25%, Medicare payments to New York's hospitals would be reduced by over $100 million. Hospitals in New York cannot make up this loss.

We believe that hospitals in any state which has a health planning system that meets appropriate criteria and that is effective in attaining specified occupancy goals or is making significant progress toward these goals should receive an exemption from any reduction or limit on capital payments.

Rational Local Health Planning

The Medicare Hospital Expenditures Amendments of 1989 permits states to establish local health planning agencies. We believe that local and regional health planning are a prerequisite to good health planning. Any new health planning system should, at a minimum, incorporate the following principles:

- retention of health planning on a local and regional basis;
- independent, credible and objective planning; that is, bottom-up planning, not top-down implementation of compulsory planning guidelines;
- local planning agency funding that is not controlled by a centralized planning agency; and
- a broadening of the governance structure of local planning agencies to include everyone in the community.

A Reasonable Occupancy Standard

I believe that the occupancy standards proposed by HR-712 are unreasonable and may lead to nationwide medical gridlock. Again, we can draw an analogy to the utilities. While an electric utility plans for an efficient capacity, it also plans for peak loads. When demand for electricity exceeds the utility's ability to generate electricity, there is a brown-out or some areas lose power entirely.

The demand for hospital services, like the demand for electricity, fluctuates. We know from New York State's experiences that if we construct hospitals for an average occupancy of 85%, then there will be many times when hospitals will be more than 100% filled. When hospitals are filled to capacity, patients may not receive the quality of care they are entitled to or even be admitted.

It may be appropriate to plan for more realistic hospital occupancy levels.

Capital Expenditure Limits

We are also concerned about the proposed capital expenditure limit. Based on our experience in New York, we would oppose this limit. A similar approach was suggested in New York State several years ago and was finally rejected by the Legislature because of the complexity of administering the program.

For example:

- If there is a fixed capital limit, what kind of criteria would a review agency use to determine which project to approve? Would these criteria be established in federal law or left to each state?
- Capital projects are often long term projects requiring several years for completion. In addition, there is a period of time ranging from one to three years between the time a hospital received regulatory approval and the time the hospital is able to obtain financing and begin construction. How would these time frames be incorporated into the expenditure limit?
- Regulatory review agencies generally approve proposed capital projects based on the estimated cost of the project. However, in some instances, the actual cost of the project may change because of circumstances beyond the hospital's control; e.g., a strike or adverse weather conditions. How would these differences be incorporated into the expenditure limit?

• How would the expenditure limit address unforeseen changes in the health care environment; e.g., the AIDS epidemic? Currently, there are 7,000 active AIDS cases in New York City. On average, there are approximately 1,900 AIDS patients hospitalized each day in New York. However, by 1994 there may be 12,000 active AIDS cases in New York City and there may be as many as 3,500 AIDS patients hospitalized each day. By the most conservative estimates, by 1994, New York will need over 4,300 additional hospital beds. How will a capital expenditure limit account for these new costs?

- How would a capital expenditure limit recognize:
  - regional and local differences in construction costs?
  - regional differences in the age of physical plants and equipment?
  - differences in the nature and type of hospital facilities that require replacement during any given year? For example, during any given year, a state may need to replace several large teaching facilities.

H.R.-712 would provide for an annual increase in the capital expenditure limit based on changes in Medicare admissions and changes in the cost of construction. This adjustment would not effectively reflect changes in the cost of construction or in the cost of equipment resulting from changes in medical technology.

Currently, the Medicare update factor reflects, although inadequately, changes in the hospital marketbasket. However, this approach only measures the impact of inflation on the goods and services hospitals must purchase. It does not measure changes in technology or medical practice.

Changes in the cost of hospital construction and, even more directly, changes in the cost of hospital equipment reflect changes in technology. A capital expenditure limit may have the effect of limiting advances in medical technology and the quality of hospital care.

CONCLUSION

The debate about how Medicare should reimburse hospitals for capital costs began over ten years ago and we seem no closer to solving it today. This debate always begins with the premise that there is something inherently wrong with the Medicare capital pass-through. Over the last eight years, this debate became entwined with theories about deregulation and competition.

I believe that there is nothing inherently wrong with the Medicare capital pass-through. It is still the most equitable way to reimburse hospitals for needed capital expense. All of the other approaches, from incorporating capital into the PPS rate to some form of capital expenditure limit, create more problems than they solve.

Chairman STARK. Dr. Waters.
Mr. WATERS. Thank you.

STATEMENT OF WILLIAM J. WATERS, PH.D., PRESIDENT-ELECT AMERICAN HEALTH PLANNING ASSOCIATION, AND ASSOCIATE DIRECTOR FOR HEALTH POLICY, RHODE ISLAND DEPARTMENT OF HEALTH

Mr. WATERS. Representative Stark. Members of the Health Subcommittee.

My name is William J. Waters, and I am president-elect of the American Health Planning Association.

It is my pleasure to appear here today to voice the support of the American Health Planning Association for H.R. 712, the Medicare Inpatient Hospital Capital Expenditure Amendments of 1989.

I have been a member of the health planning community for over 20 years. In fact, in 1970, when I was in the U.S. Public Health Service Commission Corps, I helped to develop 1122 program, the first Medicare Hospital Capital Expenditure Review Program.

The American Health Planning Association has been in continuous existence for 18 years. It continues to represent State and local health planning agencies and national organizations committed to the principles of community health planning.

Today, 45 State agencies and 40 local agencies are still active in the field of community health planning. Thus, there is a system out there that can be utilized for the purposes of this proposed legislation.

H.R. 712 is good legislation that provides a solution to real problems, and it is a new policy. It sets limits on Medicare payments for capital that are long overdue. It addresses the fact that a 40 percent idle standby staff bed capacity is an incredible waste of resources in these tight times.

It draws upon and supports the existing efforts of States to restrain capital spending. It recognizes the market value in the case of capital expenditures and provides new incentives supportive of PPS goals.

It supports a system capable of evaluating changes in capital behavior, allowing future policy adjustments to be based on careful analysis.

It allows for adjustments to support needed institutions such as rural health care facilities, and public hospitals.

It makes clear that there is a public interest in how and where capital collars are spent and that all parties need to be involved in decisions that affect communities for decades.

My own State of Rhode Island has had a statewide limit on capital expenditures since 1984. Prior to 1984, legislative amendments CON jurisdiction was limited to consideration of public need only with no explicit authority to determine what was affordable to the community or to establish any budgetary limits for capital expenditures.

The 1984 amendments modified the CON program by establishing one filing date for all hospitals to compete for a limited amount of capital expenditures, providing for the establishment of an

annual CON-cap limitation on the amount of first full year's interest and depreciation for needed hospital capital projects, and providing a priority and ranking process for all competing hospital projects within the limits of the annual CON-cap.

The results of our program to date are as follows:

Number 1, the principal outcome has been that hospitals have had to compete for a limited pool of capital funding.

Number 2 since interest expenses are a component of a CON-cap, the percentage amount of equity commitment has increased.

Number 3, the scope or dollar magnitude of certain projects has been reduced; and

Number 4, a formal process has been established for determining affordability in setting priorities among competing interests within a public forum.

H.R. 712 represents a genuine watershed in the history of hospital capital expenditure review.

The 1950's were characterized by voluntary reviews with no teeth. The 1960's were characterized by public reviews with no teeth. The 1970's were characterized by regulatory reviews with no economic boundaries. The 1980's were characterized by neglect.

H.R. 712 is well designed for the 1990's and beyond. There needs to be a budgetary limit for Medicare Inpatient Hospital Capital Expenditures. It is totally unrealistic to operate such a significant part of the Medicare program in an open-ended fashion.

If ever there was a need for careful budgeting at the Federal level, surely it is now. Moreover, the States need a budgetary limit. Without a budgetary limit at the State level, there is an incentive to maximize Medicare dollars flowing into the State and a disincentive to deny local projects, even if they are not needed.

Inpatient hospital capital expenditure review without a budgetary limit is not practical. Determining what we need is only half the battle. Determining what we can afford is the other half of this discipline. This is true when it comes to our homes, to our businesses, and it needs to be incorporated in hospital capital expenditure review.

In essence, H.R. 712 gives capital expenditure review an essential ingredient which has been lacked over the past 20 years, the healthy discipline of a budgetary constraint.

In conclusion, I want to thank you on behalf of the American Health Planning Association for this opportunity to share our views on H.R. 712.

[The statement of Mr. Waters follows:]

STATEMENT OF WILLIAM WATERS
AMERICAN HEALTH PLANNING ASSICATION

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE:

My name is William Waters. I am President-Elect of the American Health Planning Association and Associate Director for Health Policy, State of Rhode Island Department of Health. I speak to you today on behalf of the Association and not in my capacity as a State official.

The Association appreciates the opportunity to appear before you in unequivocal support of H.R. 712, the "Medicare Inpatient Hospital Capital Expenditure Amendments of 1989." We commend the Chairman for introduction of this necessary legislation.

It is our view that decisions about the health care system should be based upon need. We believe that decisions about the future size and distribution of the health care system should be made through a public process which involves all who will be affected by the decisions - users, purchasers, and providers.

We do not believe that decisions about the size and distribution of health care services and facilities should be made by individual providers acting in isolation or exclusively in institutional self-interest. Most importantly, we do not believe the current policy of cost-based reimbursement, without federal policies to provide restraint, are working. The Ways and Means Committee's data on escalating capital costs should put to rest any faith in the theoretical assumption that prospective payment for operating costs contains sufficient incentives to restrain capital spending.

It is important to note from the outset that the legislation under consideration today is not a renewal of federal support for health planning as it was in the past.

To paraphrase a recent car advertisement, what is proposed in H.R. 712 is "not your father's Roadster - it is a new generation." This legislation offers a new system for providing discipline and incentives for restraint to a health care system run amok. What is proposed is consistent and supportive of the goals of the prospective payment system (PPS) enacted in 1983.

Ironically, the Federal government, despite its withdrawal of support for planning, continues to reap the benefits of State policies that are providing the only restraint on capital expansion in this country. It is a fact that 36 States and the District of Columbia continue to operate Certificate of Need (CON) programs and that only 3 States have repealed their CON laws since repeal of the Federal Act.

The health planning community offers a unique perspective on the issue -- 20 years of experience attempting to restrain capital expenditures which have been reimbursed on a cost basis, without any established limits.

Health Planning is nothing more than a process of defining State and local health care needs with the formal and explicit involvement of all affected parties - users, purchasers, and providers of health care.

Certificate of Need is merely a tool that the health planning system has used to maintain the balance between quality, cost, and access concerns. In the past CON was used as a relatively mild gatekeeper to a payment system that reimbursed on a cost basis, without limit.

We have learned from this 20 year experience. We have learned that it is hard to say no to powerful providers and community leaders when payers offer open-ended cost-based reimbursement; we have learned that saying no begets enemies who lobby legislatures to withdraw Federal and State support for planning; we have learned that hospitals use capital and new services to compete for physicians and patient share rather than use price competition; and finally, in recent years we are learning that the absence of a Certificate of Need program, or gatekeeper, results in higher cost, greater duplication of services, decreased access for some patients and a "stand-by idle capacity" that no industry should maintain.

H.R. 712 draws on the lessons of the past 20 years and offers a new and meaningful approach to the issue of excess capital expenditures.

Like it or not, most of us would have to agree that the passage of the Gramm, Rudman, Hollings Act has changed the budget process, introducing incentives for action. H.R. 712 would do no less for the health care system -- for the first time explicit limits would be set and all parties would be given incentives to cooperate to determine where scarce resources are allocated.

We believe that a planning process, as embodied in H.R. 712, is the best way to allocate within established payment limits. It is necessary to assist Federal payment policies by defining and identifying unmet needs and system excesses.

Once the basic decision is made that limits on capital costs are needed in the hospital industry, tools, such as planning and certificate of need, are appropriate mechanisms to balance cost, access, and quality concerns. In the majority of States, agencies to carry out the new policy are already in place.

We urge enactment of H.R. 712, because:

CAPITAL EXPENDITURES BY HOSPITALS ARE A PROBLEM FOR COST, QUALITY, AND ACCESS.

- Despite dire predictions from hospital representatives concerning the "record" number of hospital closures in 1988 (i.e. 81) , a recent survey of construction and architectural firms by Modern Healthcare magazine reported construction completed on 93 new acute domestic hospitals and ground broken on an additional 93 hospitals in 1988.

- The relatively recent experience of a tremendous expansion in services and facilities in the deregulated States leads us to conclude that the management incentives inherent in the prospective payment system for operating costs have not been strong enough to offset the inappropriate incentives in cost-based payment for capital.

- Some much needed hospitals in this country, such as public hospitals are undercapitalized. An adjustment process is needed to ensure quality services to Federal beneficiaries.

- If policy makers accept the advice of the recent Federal Trade Commission study and subsequently find themselves with a building boom triggered by deregulation, that "mistake" has 15 to 30 year consequences of higher health care costs. Unlike operating costs which can be easily adjusted to correct for over or under payment, capital expenditures, once made, result in long-term cost commitments which cannot be easily abandoned.

THE CHAIRMAN'S PROPOSAL IS THE ONLY MEANINGFUL PROPOSAL BEFORE THE COMMITTEE.

- The hospital industry is seeking both continuation of cost-based reimbursement from Medicare and a regulatory free environment in States. To not take action now is to grant hospitals the freedom to use tax dollars to expand services to meet institutional needs to increase market share.

- As we indicated to the Committee in an earlier written statement, if you do not enact H.R. 712, we urge you to immediately begin to move toward prospective payment for capital. Although we clearly favor a planning approach as the best policy, we favor any policy that addresses the real problem of excess capital spending. To do nothing serves no public purpose whatsoever.

- The budget proposal to reduce capital payments by 25 percent, although better than nothing, is unlikely to be effective. Recently, a hospital, just across the Potomac, announced a $90 a day increase in room rates due to "increased uncompensated care." According to the Washington Post reports, the hospital's definition of "uncompensated care" included the estimate that Medicare was paying 15% less than cost for capital. We have no reason to believe such cost shifting will cease because the amount withheld is increased from 15% to 25%.

H.R. 712 IS GOOD LEGISLATION THAT PROVIDES A SOLUTION TO REAL PROBLEMS AND IT IS NEW POLICY.

- It sets limits on Medicare payments for capital that are long overdue.

- It addresses the fact that a 40% idle, stand-by staffed bed capacity is an incredible waste of resources in these tight times.

- It draws upon and supports the existing efforts of States to restrain capital spending.

- It recognizes the market failure in the case of capital expenditures and provides new incentives supportive of PPS goals.

- It supports a system that will evaluate changes in capital behavior, allowing future policy adjustments to be based on careful analysis.

- It allows for adjustments to support those institutions -- such as rural health care facilities, and public hospitals, most needing support.

- It makes clear that there is a public interest in how and where capital dollars are spent and that all parties need to be involved in decisions that effect communities for decades.

IN CONCLUSION, WE URGE THE COMMITTEE TO CONSIDER THE CONSEQUENCES OF INACTION, AND TO ENACT H.R. 712, WHICH WE CONSIDER NEEDED AND EFFECTIVE LEGISLATION TO TACKLE REAL AND SURMOUNTABLE PROBLEMS.

Thank you for the opportunity to share our views with you. If we can be of any additional assistance or submit additional data, we stand ready to do so.

Chairman STARK. Thank you, Doctor.

Jack, for a retired person, you certainly are hopping around these days. Welcome back to the committee. It is good to see you as always.

We will now hear from the American Hospital Association in the form of once-retired, Jack Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman.

I appreciate this opportunity to testify before this august body on behalf of the American Hospital Association for the last time as a Director of the Washington Office of the AHA.

I want to thank you personally and other members of the committee for the support you have provided at the time I have been here. Although we did not always agree on how best to accomplish our purposes, the goals of maintaining a viable, efficient health care system is what we were all seeking.

Although the PPS system has accomplished many of the goals we both wanted, it has been disappointing, especially in the area of capital payment, where predictability is most essential, because, once committed, there is little that can be done by a hospital to reduce its capital debts.

It has been extremely disappointing and frustrating to adequately explain to Congress that because PPS was so successful in limiting the length of patient stays and moving patients from an inpatient setting to an outpatient facility, that there was a natural result of a lower occupancy in our hospitals, even though Medicare only pays its portion of the capital costs based on the number of patients using the facility.

The bond obligations and borrowed debts did not decrease for these hospitals.

And I would like to quote from Modern Health Care, an article that appeared just this February from an analyst at Dodge Construction Potentials, and pointing out that the highest total ever recorded for hospital construction was 84 million square feet in 1983, which was before the prospective payment system started, but right in the middle when all of the planning was taking place.

A survey of construction and architects indicates that half of the respondents said that the largest source of construction work will be for hospital-based outpatient care. Fourteen percent chose retirement communities with health care facilities attached, but only 18 percent expected new construction to present the best opportunity in 1989.

And I think the question came up a number of times about occupancy, and if you would look at the outpatient growth, you convert that to inpatient equivalent, and we would be running about an 81 percent occupancy, where all industry is running about 84 percent.

You could liken it, maybe, to a hotel that had a lot of rooms, and then decided that they were going to offer meeting room space for meetings and found out there was another way of providing revenue for that hotel besides just using the rooms. And hospitals have been in that same situation.

Many of the capital debts were incurred under a certificate of need program, in which Medicare contracted——

Chairman STARK. Could I say—Jack, right there, look, that makes good sense. I like what you are saying, but what do you do about the hospitals, like in New York City, and the county hospital in Oakland, California, that are already 100-percent occupancy?

Under your theory, they would go to 150 percent occupancy, right?

Mr. OWEN. No, not quite. Let me finish, and then I'll come back and discuss it with you. I don't think that would happen.

Many of the capital debts were incurred under a certificate of need, as I mentioned. Medicare had contracted to pay 100 percent of the cost for their percentage of patients, and we have watched this erode over the past several years to 85 percent of the capital costs incurred, and now the administration is asking for an even larger cut. Unfortunately, the financial institutions are not willing to reduce the debt commensurate with the occupancy rate of the hospital.

Hospitals, on the other hand, have been reluctant to include capital as part of the DRG payment, although that's understandable because of the lack of predictability in the payment method.

There are, however, many hospitals who have no debt at the present time but will need capital for renovation, expansion and needed clinics and services, such as laboratories and x ray facilities. The present system of passing capital through after debt is incurred prohibits them from putting money aside to meet their capital needs in the future.

To take the money now spent by Medicare for capital, and redistribute it to all the hospitals would create financial havoc for those hospitals that have incurred substantial debt, and there is no way of reducing that debt.

I have here, Mr. Chairman, I know you love to get lots of statistics, list of those hospitals in the country who have bond obligations. I didn't make them part of the record. You may or may not, but I have enough here for the committee. I will leave it up to your good judgment; but I would hasten to add it may not be all-inclusive, but it is the best we have to work with from the financial markets. I am also giving you a summary of upgrades and downgrades of hospitals' bond ratings. Many of these rating drops have occurred because of the unpredictability of payment as seen by the bond market.

The downgrades are running about 3-to-1 at the present time. There are about 304 hospitals downgraded with only 57 upgraded.

Our official position, as I have stated many times, on capital payments is to abide by the laws worked out in the budget reconciliation 2 years ago. That is: return to the 100-percent capital rate October 1, 1989.

However, we recognize that the budget constraints under which you are working and the time has come when we must, I think, address the following two or three issues I am going to bring up:

First, any plan of proposed legislation must have an element of predictability for the financial markets and for the hospitals. We are facing an aging population, in addition to an AIDS epidemic, all demanding more health care services.

In this last year, capital dropped 3.5 percent, it dropped 7 percent, it dropped 12 percent, and it dropped 15 percent, and now we are faced with an 18 to 25 percent cut. That kind of predictability on long-term capital debts can't continue if we want to keep a healthy system.

Second, if capital is to become a part of the prospective pricing system, we must devise a way to protect committed capital so as not to lead many of our major institutions into bankruptcy.

Grandfathering old capital with our tight budget restrictions would leave very little for new capital. I recognize that. If a reduction is made to committed capital, it must be phased over a reasonable length of time. Any money taken from such commitments should be disbursed to all hospitals not just become a saving.

Those hospitals with little or no debt should have an opportunity to obtain capital over a period of time, to allow for renovation or expansion of services. However accomplished, there must be a commitment from Congress to continue to fund a reasonable capital payment, not to look upon those funds as profits to be eliminated. And that's what we were faced with early in this game.

Finally, there must be some kind of an adequate appeals mechanism to allow for special need such as new hospitals, or hospitals with specific financial problems, whose capital needs have been delayed due to regulation barriers such as we have been witnessing in New York City, as Dan so eloquently stated.

I have serious doubts that going back to certificate of need through a planning process is going to olve our problem. Having lived through planning at a State level, and observing it on a national level, it was not nearly as effective as the PPS program in reducing capital expenditures.

Our hospitals have already experienced reductions in capital for needed capital improvements that were certified by State agencies. There was a problem of State administration brought out today. The problem still remains on budget constraints because even if your bill is passed, what if the next Committee of House Ways and Means decides to cut the capital payment even though the States have agreed on a cap?

I would also caution the committee that a certain amount of surplus capacity is needed. Again, I would cite New York City as an example. It is only a matter of time before the next city faces a similar crisis with an overload of AIDS patients and those patients awaiting placement in postacute facilities.

In summary, I would urge this committee to develop a long-range plan for capital payment to hospitals, one that is predictable to Medicare, hospitals, and financial markets. Once developed, we are going to have to insist, whatever administration is in power, it abide by the plan, not use it as a convenient tool to move moneys to other domestic programs.

Once committed, there is little a hospital can do to change its capital payments other than debt restructuring.

Again, my thanks to you, Mr. Chairman, and the committee, for your courtesies during my tenure at the American Hospital Association.

Thank you.

[The statement of Mr. Owen follows:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
Medicare Capital Payments

March 13, 1989

SUMMARY

Hospital capital spending has been guided by the demands of Medicare's prospective payment system and has been responsive to legitimate health care delivery needs. Declines in average occupancy and the number of hospital beds are a direct result of PPS limits and the availability of new technology that makes more care feasible on an outpatient basis. Capital is necessary to respond to these shifts in health care delivery, for investment in new technology, and modernization and renovation of existing facilities. PPS limits on operating revenues act to restrain capital spending. Occupancy is simply a measure of inpatient capacity and indicates nothing about how a hospital is using all of its resources to provide a range of services, both inpatient and outpatient, to its community. A new mandatory federal capital expenditure review program is not needed because there are effective limits to unnecessary capital spending already in place. While a cap on capital expenditures as proposed by H.R.712 may prove a more direct limit on capital expenditures in some areas, the appropriateness of the cap's role is questionable in the logical and needed distribution of capital investment in the health care system.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA) and Director of its Washington Office. On behalf of its more than 5,300 member hospitals, the AHA welcomes this opportunity to comment on Medicare capital payment issues, including H.R.712, the "Medicare Inpatient Hospital Capital Amendments of 1989." The AHA shares the deep concern of Congress regarding the role of capital spending in the efficient and appropriate delivery of high-quality hospital and health care services. Continued availability of capital is essential to hospitals if they are to meet the nation's rapidly changing health care needs. The AHA supports efforts to ensure that Medicare capital policy furthers the goals of efficiency in hospital operations and continued access to hospital services in all parts of the country.

APPROPRIATENESS OF HOSPITAL CAPITAL SPENDING

Hospital capital spending has been guided by the demands of the prospective payment system (PPS) and has been responsive to legitimate health care delivery needs. For many years in the post-World War II era, capital spending by hospitals was strongly encouraged by the government. The Hill-Burton Program enabled establishment of many small hospitals in rural communities that otherwise would not have had access to such services, and urban hospitals were encouraged to evolve into the modern medical centers that we have today. When the Medicare program was first implemented in 1965, adoption of cost-based reimbursement for this program continued to encourage capital development within the hospital field so that hospital services would be widely available. As the costs of health care escalated, however, there was a reassessment of cost-based reimbursement because it appeared to encourage overutilization of inpatient hospital services. As a result, PPS was implemented in 1983 in an effort to control the escalation of hospital operating expenditures and our dependence on hospital services.

Hospitals have responded to the incentives of PPS, and the pendulum has now swung the other way. Average occupancy has declined from 73.5 percent in 1983, to about 65 percent in FY 1988. The number of community hospital beds in the United States during this same period has decreased 5.8 percent, and the number of general acute care beds has decreased 14 percent between 1983 and 1987. This decline in average occupancy and number of beds is a direct result of PPS limits on inpatient operations and the availability of new technology that makes more care feasible on an outpatient basis.

There is further evidence that hospitals' response to PPS incentives has resulted in decreases in utilization of hospital services. In the five fiscal years since PPS implementation, there has been a decrease of 6.7 percent in the admission rate of patients 65 years and older (and 11.6 percent for all patients), a reduction in average length of stay of 10.0 percent for patients 65 and older (and 6.1 percent for all patients), and a reduction in patient days of 16.0 percent for patients 65 years and older (and 17.0 percent for all patients).

Implications of PPS for Capital Spending

These dramatic changes in inpatient utilization obviously signal dramatic changes in the way health care services are being delivered and in the facilities needed to deliver those services. Hospitals need to modify their facilities in line with decreased demand for acute inpatient services; the more intense services often required by today's more seriously ill inpatient; and the increased demand for other services, particularly outpatient services, transitional services, and home care. (Beginning in 1985, the number of outpatient visits exceeded the number of inpatient days of care.)

Certain capital investment is required to respond to these shifts in care delivery. Capital is necessary for hospitals to consolidate, to merge and form systems that will better serve the needs of their communities, and to provide for the non-inpatient health care needs of those they serve. The process is underway, but it will take time to retrofit an entire health care delivery system. What took 30 years to build cannot be completely modified overnight.

Substantial advances in new medical technology in recent years have also exerted pressure on hospitals for new investment. Without such investment, patients will not be able to benefit from the highest quality of care that could be made available. But there are restraints already in place on such spending: PPS limits on operating revenues. Advanced medical equipment requires specially trained personnel. Arthur D. Little, Inc., for example, estimated that every $1 in equipment generates $0.22 in annual operating costs. Therefore, in addition to the fact that capital continues to be paid on a discounted cost-pass-through basis, the incentive to substitute capital for labor is not very great since any decision to make a major capital expenditure has implications for operating costs. The real need for such expenditures is scrutinized by hospitals accordingly.

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In addition to capital required to modify services and facilities, there is a substantial need for renovation and modernization of hospital inpatient facilities, particularly those built in the earlier years of the Hill-Burton programs and before. For example, a number of hospitals in New York City serving inner-city populations have had to undertake major capital projects to renovate and modernize facilities that are 50 years old or older. Other hospitals around the country have had to undertake similar projects simply to be able to comply with local health and safety codes and licensure requirements. Of course, an important goal of the renovations and modernizations is improvement in the efficiency with which the space of these facilities can be used. This ultimately contributes to cost-effective delivery of hospital services.

Finally, in some areas, it has been argued that competition has caused hospitals to maintain competitive capital structures and that capital spending that has occurred is somewhat duplicative and not entirely appropriate. In any competitive industry there are cycles when new competitors enter the marketplace and some oversupply of services or products occurs. However, as in other industries, where prices have limits, this oversupply eventually is eliminated from the system. For hospitals, not only are prices limited but the quality and appropriateness of services are monitored, so we can expect that over time whatever oversupply of services that does exist will be eliminated.

Access to Capital

Of major concern to many in the hospital field is the problem that appropriate and needed capital spending will not be possible because of financial constraints. The major source of capital for hospitals overall is private capital debt markets, in particular, tax-exempt bonds. While hospitals that do well financially should expect to be able to continue obtaining capital in this manner, an increasing number of hospitals are not doing well financially under current payment systems that often do not even cover the costs of providing hospital services.

This growing number of hospitals, many of which are the only hospitals in their area or are the major health care facility serving an inner-city area, will find it very difficult to obtain money from private capital markets or elsewhere at an affordable price. An increasing number of hospital bond downgradings in recent years illustrates this problem. According to information from Standard & Poor's, the ratio of downgradings to upgradings from 1983 through 1985 was 3 to 1, compared to a ratio of about 8 downgradings for every upgrading from 1986 through 1988. Over the period from 1983 through 1988, Standard & Poor's has reported 304 hospital bond downgradings and only 57 upgradings. Thus, our main concern over the next decade, again, should be how to maintain the infrastructure of the hospital industry and access to care, rather than focusing exclusively on how to eliminate excess capacity.

Additionally, we must be prepared to respond to the health care needs of the future. The continued growth of the elderly population will result in ever-increasing demand for hospital services. The number of Americans age 65 or over is expected to increase 10 percent by the end of the decade. During the same period, the number of hospital beds occupied by those 65 and older is expected to increase nearly 15 percent.

Occupancy As a Measure of Efficiency

It has been argued that high occupancy hospitals are more efficient and low occupancy hospitals are less efficient. In fact, occupancy levels say very little about the efficiency of a hospital or a system of hospitals. Occupancy is simply a measure of inpatient capacity and indicates nothing about how the hospital is using all of its resources to provide a range of services, both inpatient and outpatient, to its community.

Although it is true that some states with high occupancy rates are projected to have relatively high PPS margins in FY 1990 (e.g., New York), and states with lower occupancy rates are expected to have lower PPS margins (e.g., California), the data also show the opposite relationship. Rhode Island has high occupancy rates but is expected to have very low PPS margins, and Utah has low occupancy rates but is expected to have positive margins under PPS.

In addition, we know that costs and revenues per case generally increase with increasing occupancy rates. Many of the higher occupancy rate hospitals are the larger urban medical center hospitals that are referral centers and care for a higher proportion of complicated cases requiring more sophisticated and costly medical care services. Many of these hospitals also are located in larger cities that have a higher cost of living and, hence, higher wage rates. Many low occupancy hospitals are small, rural and have low capital costs and low total costs per case. This apparent relationship between cost and occupancy, however, is not causal but irrelevant and even misleading.

Further, analyses show that the relationship between occupancy and costs is complex and that simply increasing occupancy rates will not result in large savings. On the other hand, the potential result of closing low occupancy rate hospitals or reducing their ability to deliver appropriate services to their communities could mean that the lower cost services they would have provided might have to be provided in higher cost medical centers.

Occupancy rates based on inpatient days understate actual facility utilization because a significant portion of a hospital's space is dedicated to the testing, procedure, and recovery needs of outpatients. If outpatient visits were converted to inpatient day equivalents, adjusted occupancy would have been 81 percent in October 1988 as compared to average capacity utilization for all U.S. industry of 84 percent.

A second and better measure of hospital efficiency than occupancy is the hospital field's use of labor. Evaluating how hospitals' staffing has changed over time in relation to the amount of care delivered gives a much better proxy of the efficiency of hospitals. Looking at average hospital full-time equivalent (FTE) hours per adjusted admission throughout most of the decade of the 1980s reveals that this ratio has remained relatively constant at a level of about 150 FTE hours per adjusted admission, arresting a prior trend of increasing staffing ratios. Given significant increases in the complexity of inpatient cases since 1983 and, thus, a patient mix that has required substantially greater care in 1988 than in 1983, hospital staff are, in fact, more productive in 1988 than before introduction of PPS.

These data demonstrate efficient hospital operation. Hospitals are appropriately staffing to meet the needs of their expected patient population. The dramatic decline in admissions and patient days has not resulted in overstaffing. Instead, hospitals have adjusted staffing levels, their most expensive resource, to the level and amount of care they must deliver. The picture evoked by the low occupancy rate of staff standing idly by waiting for patients to be admitted is a myth.

The Cost of Excess Capacity

Capital expenses are fixed and must be met regardless of hospital utilization. Even if capacity is reduced, payment has to be made for these fixed expenses. Substantially limiting Medicare payments for these already fixed costs forces hospitals to dip into operating dollars to meet capital obligations. This further decreases hospital margins, a substantial portion of which are already negative. The undesirable result will be elimination of needed hospitals and hospital services and reduction in access to hospital care for Medicare beneficiaries, as well as others in the community.

In terms of operating costs, Medicare payments are already limited by per case DRG rates. The Medicare program pays for each hospital stay of a Medicare beneficiary according to these rates and does not incur any additional costs beyond those rates because of excess hospital capacity. Even aside from this automatic limitation on the level of hospital operating costs that the Medicare program can incur, some estimates of hospital excess capacity costs are extreme.

The Grace Commission's estimate that the cost of an empty "staffed bed" is $33,281 per year in 1981 dollars is based on misleading information. In fact, when hospitals report "staffed beds" they are essentially reporting "beds available for staffing," but they only staff the hospital and appropriate number of beds within the hospital according to what they expect their actual patient load will be. There is no incentive for hospital managers to unnecessarily staff a hospital bed, given PPS per case payment limits. Had they done so, per case costs would be even greater in relationship to per case payments, and we would be seeing even lower hospital operating margins than we are seeing today.

By assuming that every empty hospital bed is fully staffed, a substantial portion of the Grace Commission's estimate of $33,281 per empty bed per year is labor costs that, in reality, are not being incurred. These labor costs are not fixed costs, but rather variable costs that are incurred only if it is necessary for a hospital to increase its staffing to accommodate a higher patient census. Again, this is further demonstrated by the fact that FTE hours per adjusted patient day have remained steady throughout the 1980s despite lower hospital inpatient utilization.
Finally, it should be noted that academic studies by reputable health care economists have estimated the cost of an empty bed at a much lower level. For example, Bernard Friedman, Ph.D. and, Mark Pauly, Ph.D., have estimated the annual cost of an empty bed at about $4,700 to $7,500.

ISSUES RAISED BY H.R.712

The stated intent of the Medicare Inpatient Hospital Capital Expenditure Amendments of 1989 is to limit Medicare's reimbursement of hospital capital-related expenses to support only those institutions and services that are truly needed. The AHA believes the current system for Medicare capital payment already serves this purpose. As previously outlined in this statement, the AHA believes capital spending has been appropriate and there are effective limits to unnecessary capital spending already in place.

Federally mandated health planning or capital expenditure review, similar to that proposed by the bill, has already been imposed on states by a federal law, P.L.93-641, passed in 1974 and repealed in 1986. Numerous studies have been conducted to evaluate the effectiveness of P.L.93-641, specifically the mandated capital expenditure review or Certificate of Need (CON) portion of that law. In 1987 and 1988, for example, the Federal Trade Commission (FTC) conducted two general studies and one state-specific study (Pennsylvania). All three studies showed that CON programs have not been effective in controlling costs and may even have acted to increase costs.

CON programs limit competition and hospitals' ability to adapt to an increasingly cost-conscious and competitive environment by:

- limiting hospitals' ability to convert existing capacity and resources to meet the changing needs of their communities;
- preventing entry of new providers into the health care market, thereby providing little incentive for existing providers to improve efficiency and develop more effective ways of providing services to better meet health care needs;
- artificially limiting supply and allocation of services or facilities such that prices may be too high; and
- opening loopholes that allow the process to be circumvented and used primarily for political purposes.

Of course, the essential difference cited in the proposed legislation between the previous capital expenditure review regulation and H.R.712 is the capital-payment ratio limitation. While this cap may prove a more direct limit on capital expenditures in some areas, the appropriateness of the cap's role is questionable in the logical and needed distribution of capital investment in the health care system.

The cap on a state-by-state basis can result in some hospitals not being allowed to make much needed capital expenditures. Specifically, a state whose Capital payment ratio is over the national limitation (and almost half the states should be in this situation) are likely to have hospitals in some urban areas that have had to renovate facilities recently and, thus, have driven the state's capital payment ratio over the average. Hospitals in other urban areas are likely to be at the end of their capital cost cycles and their facilities in desperate need of renovation. Because the state would already be above the capital-payment ratio limitation, these latter hospitals could not make needed renovations.

Additionally, linking the Medicare capital payment system to occupancy levels would undermine PPS incentives and penalize hospitals for responding to PPS. The Prospective Payment Assessment Commission has recommended that an occupancy adjustment would not be suitable. PPS already disadvantages low occupancy hospitals because it is a volume-based system. Declines in Medicare admissions have reduced payments to low occupancy hospitals under PPS.

Further, the capital-payment ratio limitation would be very difficult to administer. It would require that projections be made about the estimated amount of DRG payments and capital payments in the state in future years when new capital projects would come on line, also taking into account the impact of capital reimbursement for movable equipment paid on a fixed basis. These projections would have to include estimates of capital payments for current capital projects as they come on line as well as proposed future capital projects. It is doubtful that accurate projections or estimates can be made. Unfortunately, their accuracy would spell the difference between the acceptance or rejection of a needed capital project.

The AHA also has strong reservations about the proposed legislation's sole focus on hospitals. Admittedly, review of proposed capital expenditures is supposed to be limited to those projects involving new inpatient hospital services or facilities, but proposed hospital capital projects often include expenditures for both inpatient and outpatient services. Which services are for inpatient versus outpatient services may be difficult to distinguish, particularly if the proposed project involves a conversion or if the project involves facilities and equipment that will be used in delivery of both inpatient and outpatient care.

Hospitals have often experienced inequities in past and current state CON programs when capital expenditures proposed by hospitals were subject to review, but the same types of capital expenditures proposed by other providers were not. This inequitable treatment creates inappropriate incentives for the distribution of health care services. If the proposed legislation is passed, there is no reason to believe that there would not be discrimination against hospitals as compared to other providers in the initiation and implementation of new capital projects for other than inpatient services.

Finally, the AHA strongly opposes incorporation of payments for new and existing capital expenditures for movable assets as a fixed add-on amount to DRG payments over a three-year period. This provision would result in inequitable treatment of and inadequate payments for many hospitals. There is substantial diversity among hospitals in the ratio of movable equipment capital-related costs to total capital-related costs. As a percent of total capital costs, movable equipment capital-related costs appear to vary from less than 20 percent to over 70 percent, according to the most recent Medicare data available. Incorporating these payments over three years, particularly when the depreciable lives of movable equipment are often much longer than three years, will be inequitable, resulting in windfall payments to some hospitals and substantial payment shortfalls to others.

There is good reason to believe that many more hospitals will fall in the latter category, however. In contrast to early estimates that average movable equipment capital-realted costs are only about one-third of total capital-related costs, more recent estimates from Medicare cost report data put this estimate at nearly one-half of all capital-related costs. Thus, the rapid transition of such a substantial portion of hospital capital costs is likely to have severe repercussions for many hospitals.

In addition to the inequities and inadequacies of capital payments that will result from too rapid an incorporation for movable equipment capital-related costs into DRG rates, implementation of this provision will be difficult because the separation of capital expenses into movable and fixed categories is administratively complex and burdensome. It would require detailed accounting and reporting by individual hospitals of which of their capital assets that are being expensed should be considered movable equipment and which should be considered fixed plant and equipment. This type of reporting and accounting also would have to be done for interest expenses, creating additional burdens on hospitals and intermediaries. These distinctions are neither uniform nor readily available from all hospitals, especially for older assets.

CONCLUSION

The AHA believes that a new mandatory federal capital expenditure review program is not needed. It is not needed because much of what it would be designed to accomplish is already occurring. There are already incentives in financing systems and in the changing demand for services for hospitals: to modify current facilities by downsizing inpatient areas and adding other services that better meet the needs of their communities; to merge and consolidate with other facilities when this seems appropriate; to affiliate with other providers and form systems of care that not only deliver services more economically but with a better continuum of care for the patients served; and even to close when this seems appropriate and necessary.

What is needed is not new capital expenditure review regulation, but incentives to assist hospitals in making these changes. Mergers and consolidations of hospitals, downsizing inpatient areas and modifying services, and even closures of hospitals can be expensive. Helping financially strapped hospitals to make these kinds of appropriate changes would promote the principles this proposed legislation is seeking to achieve without the expense and rigidity of more regulation. In fact, in the Health Planning and Resources Development Act Amendments of 1979 and in the Omnibus Reconciliation Act of 1981, Congress included provisions that would have assisted hospitals in making these kinds of changes, but these provisions were never funded or implemented.

Furthermore, removing barriers in current regulation, rather than providing more regulation, would greatly promote the types of changes in the structure and delivery of hospital services being sought by this legislation. A growing number of states have already decided that capital expenditure review regulation has not been effective and have repealed laws supporting this regulation. With only a few exceptions in these deregulated states, hospitals have been making prudent capital investment decisions, recognizing the need of their communities and the limits of payment systems. Those states that still have capital expenditure review programs are moving toward relaxing this regulation to make it easier for hospitals to respond to financing and market incentives. These states are increasingly questioning the effectiveness of their capital expenditure review programs, and many are gradually eliminating these programs.

The AHA is looking carefully at all the issues involved in the modification of the heath care delivery and financing system to better meet current health care needs. Many of our educational activities have focused on hospital diversification efforts, mergers and consolidations, more efficient management of hospital operations, and hospital responsiveness to community needs. Beyond these activities, however, the AHA is undertaking a major effort to determine what incentives will best encourage the expeditious modification of hospital services to efficiently and effectively meet community needs. The first step in this effort has been to help assure that hospitals are paid adequately for the services they deliver. This is already well underway with the AHA's Medicare reform initiative. The next step, also currently underway, involves a careful examination of the overall financing and delivery of hospital services and the development of policies that will support the rational distribution of these services.

Chairman STARK. Thank you, Jack.

Let me just give you two problems. You touched on the New York problem, and I think we would agree, they need help. Because of certificates of necessity or strict controls, they have run at a very high occupancy, and they have not built their plant, particularly in New York City. It needs a lot of work.

Now, you are probably not familiar with the geography of my district, but in a suburban area, where there are two cities, each with a hospital, each hospital doing OK, one a little better than the other, but both with modest occupancies, high fifties, maybe; and a new community is expanding in between them, kind of popping up out of nowhere.

But, arguably, because both hospitals have suggested this, the new community needs 100 beds, max; and that makes sense because these two communities, each with about 100-bed hospitals within driving distance, and now serving the community, and they are both half empty. Both hospitals are building two new facilities, because they can't get together and agree, and they both are going to operate, and then we are going to have four hospitals, half empty.

Why is that as important as directing some of that capital to New York City where, arguably, it is imminently needed. These are acute care hospitals, and I am not cooking any number; that's about right.

Aren't those two different cases? Isn't the New York City case a stronger case?

Mr. OWEN. I would have to argue that it is. I don't think——

Chairman STARK. Now, all we're trying to get at is the fact that we have limited resources.

Mr. OWEN. Right.

Chairman STARK. Now, under the theory that we give everyone as much capital as they want, on the one hand, and we restrict costs indirectly through DRG's on the other, there is an unnatural pressure to spend capital.

You get your money back for the capital, and to the extent that even marginally you can replace labor with capital, I don't blame a hospital administrator for going overboard on capital, and particularly to the extent that they can get modest returns the other way.

I won't argue that occupancy is necessarily the measurement, but I think we will both agree that there is imbalance, or there are different levels of need.

If we don't have enough money, how would you suggest we allocate scarce capital among your 6,000 members?

Mr. OWEN. Well, let me go back to the situation.

In the New York situation, for instance, most of that capital has already been committed, or what's there. What they need now is for new capital because of the restriction, and that is what I'm arguing for, that they should have it because of need.

Chairman STARK. OK, but how do I give it to them, and not these guys in my district who arguably don't need it?

Mr. OWEN. Well, I am not advocating that there be unlimited amount of capital. I think that there is evidence that——

Chairman STARK. But how do we ration it then? Congress is going to have to set the priorities, that might be an argument be-

tween Mr. Anthony and Mrs. Johnson as to whether it ought to be rural or urban, but once we agree to that, and I'm assuming there isn't enough capital or capital reimbursement under the present budget constraint, how would you suggest we allocate that capital?

Mr. OWEN. Well, if you took and guaranteed, or had some kind of a commitment to that capital which is already committed——

Chairman STARK. OK, let's put that aside. That's behind us.

Mr. OWEN. OK.

Chairman STARK. Let's talk prospectively only.

Mr. OWEN. All right.

And we are talking about prospective; we've got two ways to go: one is to eventually bring it into the DRG pricing mechanism, which at that point it's a part of the price, and the hospital makes a decision on whether they build or not on the basis of the ability to pay off the debt, and the hospital in California couldn't pay off the debt, I wouldn't think, would go ahead and build when they had no guarantee of getting any money back.

Chairman STARK. Do you think——

Mr. OWEN. They were not guaranteed any more.

Chairman STARK. Are you suggesting that the AHA would support paying for capital through the DRG?

Mr. OWEN. I'm suggesting that it's worth looking at at this stage—I can't speak, unfortunately, I can't speak for the AHA any more, but I think there has been enough discussion that if there were some way to accomplish this over a long period of time and protect the committed capital out there, that they would be favorably inclined to look in that direction.

There are certain states who don't feel that way, certain hospitals who don't feel that way, but I think overall those hospitals that I've run into across the country who have no capital debt would like to have an opportunity to put some money away.

Chairman STARK. Good.

Mr. OWEN. And they have no opportunity until they spend it.

The other thing would be, and I'm not sure that your bill says it, but if your bill does have an aggregate cap—I had problems with trying to figure out how you are going to develop your bill in the State. Some 23 States would not have any moneys eligible under your bill, as I understand it. I may be wrong, and I would have to look at it a little closer, but that's the problem with it.

But, even if your bill is enacted, and there is a dollar amount that is approved, what kind of assurance does a hospital have that the administration, whatever that administration might be, won't come back and say, cut capital some more. Now, you are committed to something in the future.

Chairman STARK. As long as they just keep me chairing this committee, they will know that I have always followed through and beaten the administration every time, so I'm the best hope they've got for keeping the administration honest.

One last question, as my light is about to go off here: Do you oppose the physician ownership—this is a little bit off the subject—of labs, imaging centers, or hospitals, to which the physicians only refer patients?

And, are you concerned about the present arrangements of this type that exist now, and about the effect they will have on not-for-profit hospitals?

Mr. OWEN. Yes, we are concerned about it. And your bill looks like it would be an agreeable bill that we could go along with.

We have a position that there should be no unethical arrangements or conditions in which a physician who owns a facility refers to it for purposes of improving his investment. That is official. I will give you that official position if you would like that, Congressman.

Chairman STARK. Thank you.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I was very interested, Mr. Owen, that you think that your organization would consider folding some of the capital reimbursements into DRG's.

It seems to me that at least the equipment issue ought to be looked at in the future as part of the cost of care, and I'll be very interested in your getting back to me whether you think the issue is divisible, and whether you think the cost of equipment could be folded effectively and responsibly into the DRG system?

Mr. OWEN. I would just comment having lived and grown up and worked in New Jersey from the start of the DRG program for 19 years. As Bruce Vladeck pointed out, we used to sit across the table from one another—he was in the Health Department, and I was representing the hospitals. It can be done, if it's done in a timely manner.

I think one of the biggest concerns that we have always had is how quickly you make that conversion, and that's been of the most concern. On a reasonable basis, we have discussed that, and I will get that back to you.

Mrs. JOHNSON. Well, I find it very hard to believe that in the United States of America in 1989, we have to have a 2-year data lag on which to make policy decisions in regard to health care.

But certainly in regard to equipment purchases, that information could be forwarded in such a way that I can't believe we couldn't get a more timely feed of data on which to make that determination within the DRG system.

If that were the case, is there the possibility in your mind that we could deal with capital allocations with a formula that took occupancy into account, but took age of infrastructure into account? Possibly took some other things into account so that hospitals that had been able to raise the capital to meet their capital needs wouldn't be disadvantaged, and so on?

It just seems to me that the plant issue could be dealt with with the formula without a lot of factors, if we could get the equipment issue moved into a more contemporary framework.

Mr. OWEN. I would not disagree. I think you have to keep in mind that a lot of the capital issued is not for new beds, but as we look at how to solve the problem of the occupancy, many hospitals need renovation to use their facilities for something else. My analogy to the hotel who uses the meeting rooms is an example of that kind of thing.

It does take capital in order to do that. Or even, for instance, to move into, say, drug abuse, or substance abuse, or nursing homes, or a skilled nursing facility. So, capital is needed there.

And then there is always the problem, as population shifts, of those areas and some places where population is going down, and there're some empty beds and you have got a new area growing up, as Congressman Stark mentioned, and how do we get capital in those particular areas?

But I think that could be done.

Chairman STARK. Would the gentlelady yield?

Mrs. JOHNSON. Yes.

Chairman STARK. Jack, you might want to respond—your first question dealt with the lack of timely information.

Mrs. JOHNSON. Yes.

Chairman STARK. There has been a bill which is now a study to get a uniform reporting from those 6,000 hospitals in the country, and, Jack, you might respond as to how strenuously the American Hospital Association supports us in that effort.

Mr. OWEN. We are well behind it, far behind it. [Laughter.]

Mr. OWEN. No, seriously, our concern basically was one of the data that is already being used was not being used very effectively, and what difference does it make what kind of data you had if the political decision was made on what you are going to pay us.

And that was part of it. But we have supported what Congressman Stark did—we have what, five States now, in the program? Two States are in the program? California and, I've forgotten the other one.

That may well work out well.

Chairman STARK. I hope that if they find that it doesn't hurt and that we will have some more timely data that is similar so that we can make more comparisons.

Mrs. JOHNSON. I thank the Chairman, and I think that study is very important.

But I think the anxiety that Mr. Owen is reflecting is one that is widespread in the health care community. They are afraid of more data, more forms, more administrative costs, and politics and decision-making.

And when I look at the amount of redtape that we are imposing on the health care sector, physicians, nursing, VNAs, and so on, I believe we do have some major reforms. But, to some extent, we can't make the major reforms without the data, so I do hope that you will make every effort to be a part of that study.

But, I believe that maybe a way that we could look at this capital reimbursement issue is to look at some of the equipment issues being built into the DRG's, and look at capital reimbursement in terms of buildings and modifications and all of that kind of thing, and different formulas.

I do want, before my time runs out, to ask a couple of questions of the Hospital Association of New York.

I'm sorry that I missed your testimony, Mr. Sisto, but I did review it here, and I'm very interested that you make the comment that overregulation and centralized planning stifle innovation, increase operating costs, and in some cases threaten to cut the quality of hospital care.

This is certainly what we heard from some members of the preceding panel, and I just wondered if you would like to enlarge briefly on that.

But, in view of the red light, let me also make one other comment. I think it is very instructive to this committee that New York regulation has put you in precisely the position of British hospitals, that you have redefined elective surgery to mean anything other than emergency surgery, that the wait for care is very long, and that 63 percent of your patient days are provided to emergency patients who by the nature of the delay in their care are requiring more intensive and more expensive care.

One could say that regulation has brought you to the point where you are no longer able to give any of the preventive care that reduces costs or regulate in a sense the health care needs of your clients in a way that is cost-effective.

Would you agree with that, and would you comment on this business of overregulation as stifling innovation and increasing operating costs?

Mr. SISTO. Well, I think it is a fair depiction of the state of crisis in the New York State hospitals—actually, the whole health system in New York State, and you might be struck that we still nevertheless come out in favor of health planning.

It is really in the last 4 or 5 years that we have seen the deterioration of our, what we consider to be community-based health planning system, because when the Federal Government withdrew its funding for health planning, the existing agencies became totally dependent on the State bureaucracy for their contracting.

So, we lost community-based health plan, and what we got was a substitute in the form of branch offices of our Department of Health being funded by our Department of Health which implemented the planning directives of the Department of Health.

If we could go back to true community-based health planning that we had in the sixties to seventies, and the early eighties, actually, we would support it.

Mrs. JOHNSON. In other words, you are saying that you would have fared better?

Do you think your budgets would have been cut less?

Mr. SISTO. No, I think that the health planning system would have been more—I think that the need determinations would have been based upon what local communities believed was necessary as opposed to what State budget policy dictated would be allowed.

What we have, in effect, is reimbursement reduction, not cost containment, and essentially, to give you a prime example—this very week, we are here in Washington listening to the potential of a 15 to 25 percent cut in capital, because of frustration, a lack of planning and CON. In New York, our Governor is proposing a budget that cuts capital 15 percent because that's what the Federal Government is doing.

That's what I mean about the worst of both worlds.

What I feel is the real problem in New York has been the total centralization of all the planning, and the fact that the business community, the legislature, the consumers, essentially play very little role now, in determining what the priority needs of the health care system really are.

Mrs. JOHNSON. What I hear you saying is that the CON process is good as long as it starts from the bottom and moves up.

Mr. SISTO. The health plan need determination, yes.

Mrs. JOHNSON. Yes. OK, you are saying that overregulation coupled with centralized planning——

Mr. SISTO. That is correct.

Mrs. JOHNSON [continuing]. Is what stifles innovation?

Mr. SISTO. That is correct.

That, in effect, what we have right now, we don't really have community-based health planning at all. We simply have a Department of Health that controls all of the rates, determines all of the bed needs, and there's just a figment of what once was a community-based health——

Mrs. JOHNSON. So, in your experience, a grassroots-based——

Mr. SISTO. Right.

Mrs. JOHNSON [continuing]. Certificate of need process did not favor established providers.

Mr. SISTO. It worked. Oh, no, no, it didn't.

In fact, the emphasis in New York State has always been as a part of any submission of a certificate of need to get it approved—first, you have to show a community need; you have to show financial feasibility, the character and competence of the providers, a quality of care assessment is made.

But there also has to be a submission that a variety of alternatives were considered for different ways of providing a service before it would be approved, so that's why the—and the other issue, of course, that's relatively new, and I did mention it briefly in the testimony, is that the hospitals in New York State have become society's catch-basin for all the problems they didn't know what to do with otherwise.

We have tens of thousands of mentally ill who were released into the streets without any community support. They found their way to our emergency rooms.

We have 2.5 million uninsured; we have between three-quarters and a million illegal aliens, so every social issue that we couldn't figure out how to deal with is now impacting the hospitals as well.

Mrs. JOHNSON. Well, thank you very much——

Mr. SISTO. So, this is what we are saying is, if that's the State of New York, CON health planning is here to stay, then as you make determinations about how to deal with the whole country, and as you look for those who try and respond to the social imperatives that we say is important to us, try and make exceptions for those situations.

Mrs. JOHNSON. Thank you very much. My time is up, but I appreciate your thoughtful testimony.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Owen, I notice you said in your testimony that hospital capital spending has been brought about because of the DRG system, that has been responsible for it as much as anything else.

I thought the American Hospital Association supported the DRG prospect payment system?

Mr. OWEN. We do.

Mr. PICKLE. You do?

Mr. OWEN. Yes, sir. Continue to do so.

But that——

Mr. PICKLE. The system that you endorsed has now caused your problem?

Mr. OWEN. Well, it has to a certain extent, although we think it does not cause as much of a problem as Congress and some of the American people think.

For instance, you're concerned about the occupancy—I know you are, because I know Texas but, if you look at what they have done in those smaller hospitals and the increase in outpatient services; and if you converted that outpatient to an inpatient figure—if you would say something like 10 outpatients equal a 1-inpatient day, you'd find that the occupancy would be about the same as about 81 percent nationwide.

And so the low occupancy isn't necessarily bad from the standpoint of the kind of care that's being rendered. It's bad from the perception that it creates to people sitting out there, and something needs to be done about it, I agree.

Mr. PICKLE. I guess what I'm trying to drive at is that when we set up the DRG's and PPS, we did it primarily at the request of the hospitals.

Mr. OWEN. That's correct.

Mr. PICKLE. And you all agreed to the system we put in place. Now, you're saying that's caused your problem, and I find—don't you think you are kind of meeting yourself coming and going?

Mr. OWEN. No, sir, let me correct that.

We have got a problem because you are not paying 100 percent of what was agreed upon, not just because——

Mr. PICKLE. That's——

Mr. OWEN [continuing]. Not that we are asking for more.

Mr. PICKLE. Well, are you saying then that the fact that we are not paying the full amount, that just affects you and not the whole medical system as a whole?

Mr. OWEN. No, what I am saying is——

Mr. PICKLE. A broader range than that.

Mr. OWEN. That is correct, to a certain extent.

What I'm saying is that when hospitals did build back in the Hill-Burton days, in the days that you talked about, they got a long-term commitment. They had bonds, and they had to pay that off. It's like having a mortgage on a house. If you lose your job, the mortgage doesn't go down; you still have to pay those off.

And what we have assumed is, even though the DRG system and the prospective pricing cut the total amount that the hospitals got, that the Federal Government is still committed to pay their portion of the capital up to 100 percent.

What's happened, however, is we have had to make up that difference now by going to other payers, and there just aren't enough other payers out there to make it up.

Mr. PICKLE. Well, I would agree with you that in rural areas, the closing of those hospitals with low occupancy simply means that they are just going to transfer patients to some other place, and I don't know that that helps the situation very much.

But I don't know that the DRG system alone has caused this problem. You said that the only way you have operated—you indi-

cated to me in your testimony that the only way you have kept this thing going is by capital investment through expenditures.

Now, I don't know why just being able to invest in capital would cause you to make that differentiation. It seems to me like some hospitals have operated by virtue of taking advantage of the capital expenditures.

Mr. OWEN. I was planning—there, with 6,000 hospitals, to say that there is none that have done it, I would be wrong, but I think the capital expenditure is something that is based on what actually has been spent.

Now, we have seen a reduction in the capital expenditures as it relates to buildings and construction since 1983 when this happened. We've seen increases in capital for movable equipment because new technology comes along.

But let me go back to maybe just a couple of comments on the rural situation in the small hospital. The hospital that's under 50 beds probably should not even be in this prospective pricing system, and we would——

Mr. PICKLE. Probably should not be what?

Mr. OWEN. Should not be in the prospective pricing system because they do not have enough patients to average out, and that's what this is all about.

So, everything you say about the less than 50-bed hospital, you almost have to start out by saying that they shouldn't even be in there to start with; they ought to have been paid on the cost, and I think that Congress could probably remove them from the PPS system and find that it is not costing really any more money out of the total Medicare budget if they paid them full cost.

The second thing is——

Chairman STARK. If you will yield. I concur with them, but then I wouldn't get Jake and Beryl Anthony to vote with me after I helped them take care of the rural hospitals, and I need their vote to take care of the inner-city hospitals, so——

Mr. OWEN. Right. But, Mr. Chairman, you are absolutely right, the problem with it is that that is not going to save the small hospital, because they don't have enough patients, and I heard you at a hearing a couple of weeks ago, say that outpatients are bypassing the small hospital, and we are seeing that happen all the time.

The question is what do you do where that is the only access point in a community in Texas where this one is way out there, and there's a standby cost, or you have got to come up with some way in which you get people to get access into the system.

It's like I went to school in a one-room school in Pennsylvania when I started out, and they got rid of one-room schools, but they didn't get rid of education as far as the rural community I was in.

You have got to do the same thing with health care.

But capital is a different issue.

Mr. PICKLE. Well, I said at the very beginning, I think that we do have a problem with the low occupancy rate.

Mr. OWEN. Yes.

Mr. PICKLE. And the States are not addressing this question adequately, and some local communities are operating on the old certificate of need, and I think we have got to have a different approach.

I don't think Mr. Stark's approach is the answer, but it's one approach to be considered.

But we should find other alternatives. Now, you say you are opposed to Mr. Stark's bill, but we have got to see what you are for, what else is an alternative, and where States, local communities can fit into it?

Maybe full staffing, as you suggest, would be another approach, but there's more to the problem than just occupancy rate.

Mr. OWEN. Yes.

Mr. PICKLE. Because I think such a capital limit would unfairly affect hospitals in a lot of the States who can't do anything about their situation under the present conditions.

Mr. OWEN. Yes.

I have——

Mr. PICKLE. Give us some help on what we can do now instead of opposing this capital limitation.

Mr. OWEN. Well, I think—I guess when you were out of the room, I suggested a couple of things. We have got a commitment to those States that already have commitments, and I've got here a list of all hospitals with bond commitments in every State across the country, which I will make available to the committee.

I also have some statistics on occupancy and cost per case, although I didn't anticipate Mr. Stark's question about which States had Certificates of Need, and I will make those available to the committee as well, which States still have it, because the interesting thing you find out is that occupancy doesn't necessarily have a strong relationship with whether a State is making or losing money on Medicare.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. One other thing that has left me a little puzzled. You are talking about a hospital, like the one in my district, and you would suggest that if it has 55 percent occupancy, part of that is due to the outpatient facilities that they may be using.

Now, I'll stipulate that part of that is due to DRG's where they have been pushed to have fewer days.

Mr. OWEN. Yes.

Chairman STARK. Whatever way.

Using outpatient facilities, if you'll agree, or just getting people out faster.

My question is why, what sense is there in saying that I should take some factor for an outpatient for an outpatient facility, which they may or may not have used—and just suddenly offset that against occupancy?

What's the logic there?

Mr. OWEN. Well, I think you have to look at each hospital. I mean, I can't speak for all of them, but let's take the hospital that was running a 75 to 80 percent occupancy.

Because of PPS now, they have dropped that occupancy rate down to, say, 55 percent. They may be seeing more patients in that community than they were seeing even when they were all inpatient, but they may be using that facility in a different fashion, and all I'd say is take a look at the outpatient and see what they did.

Chairman STARK. I would stipulate that you are absolutely right if it's a fixed community, and there have been no new providers in the community.

Mr. OWEN. Right.

Chairman STARK. But where, in the process, there has been another new facility built, which is an acute-care facility, and there's enough competition, then all we're really doing if they build another is taking it away.

In the aggregate, I think you are wrong. Specifically, I think you are correct, but if you aggregate a series of hospitals—we've got one in El Paso now that went broke. And they are resurrecting it by selling interests in it to referring physicians and giving a commission on every patient they send, a 20-percent commission on every patient, for all hospital billing.

I hope you kick them out of the AHA for that, or don't let them in.

Well, the point is, that's got to take patients away——

Mr. OWEN. Yes.

Chairman STARK [continuing]. From the other hospitals in El Paso.

One presumes they are still open because they are providing good service. It just boggles my mind that we should provide any capital for those hustlers, and that's the problem.

If it was the only hospital there, you say, fine; they need the service; but you can't take this out of context for the other providers in the community who——

Mr. OWEN. I don't disagree with you.

Chairman STARK. The marketplace doesn't do it, Jack.

Mr. OWEN. Yes.

Chairman STARK. We heard a gentleman here from the FTC talk about the market, but that's purchased by insurance company; the public doesn't buy hospital service.

Somehow, we have got to figure out a way individual hospitals will act as individual businesses. The hospital administrators are paid to worry about the aggregate in the community. The Sisters of the Poor, or the local trustees they have community pride—they want to keep that institution alive. To hell with the other hospitals, is their attitude. I don't blame them.

Now, somebody, therefore, has to, if they are using government resources, figure out how to allocate the resources; and it's not a criticism; it's just an understanding that individual hospitals won't make that decision; it is not in their interest to do it; and it is like voluntarily sending in $50 and a guilty plea every time your car goes over 55 miles an hour on the Dulles Road. You just forget to do that. [Laughter.]

You know it would be a wonderful idea, but don't count on it.

Mr. OWEN. But let me just caution you on one other thing, and that goes back to when all this happened with planning and part of the reason, what occurred was, as these things moved out of the hospitals, the hospitals were the only ones that most States had on a certificate of need. And we saw other outside groups.

If you are going to only control one segment of the health care industry, how do you prevent this other thing from happening? That's what worries me.

Chairman STARK. Well, I don't like planning as a general rule—except I think I would be happy to see it come back in the airlines. Boy, would I vote for that, and I wouldn't suggest that it wouldn't pass the House awfully quickly.

But I'd buy the DRG system, as you say, prospectively. If you could find out what was a fair hold harmless, and by "prospectively," I don't mean the dream of the new building that is in the trustee's eyes right now, and they haven't even picked the architect.

They just talked about it to three people. That is not what I think about.

Then I don't think the DRG system is very perfect. But if you want to know the best way and the fairest way to allocate capital, put it in there, and then each hospital makes, as you said, their own decision, and that would be all right with me.

But that was originally opposed by a lot of hospitals. That's basically what you do when you follow the administration's proposal, just cut back on the capital. That means they have got to look to the DRG's to pay it.

There is a certain obligation, and I accept that for capital programs that were put in place in reliance on the old law.

I'm not sure that a continual refinancing of those facilities, however, was what we anticipated. And, so that at some place, if we could find a fair hold harmless, I think moving toward the DRG system would be the simplest way to do it, and it wouldn't require a bureaucracy.

But, thank you, again.

Mr. OWEN. Thank you, Mr. Chairman.

Chairman STARK. I thank all the witnesses, and I hope that you will work with us to see if we can find some kind of a solution.

Mr. OWEN. I'll give you these bonds, Congressman, and then I'll——

Chairman STARK. But let me warn you, if the administration prevails, if I tire, if I weaken, you get a $5 billion cut from your friendly Republicans, that all those hospital administrators voted for. You will be in deep trouble, guys, so remember who's helping you.

If we don't get it down to $2 billion, or undercut 25-percent capital reduction, it is going to look awful good to you.

Mr. OWEN. Yes, sir.

Chairman STARK. Don't forget that exception.

Mr. OWEN. Thank you.

Chairman STARK. The committee is adjourned.

[Whereupon, at 3:43 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of Michael D. Bromberg, Federation of American Health Systems

The Federation of American Health Systems is the national association of investor-owned hospitals and health systems representing over 1,?00 hospitals with over 154,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, the investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on capital financing under the Medicare program.

Background

Congressman Stark (D-CA) proposes to end Medicare payments for capital as of October 1, 1990 unless the average statewide occupancy of licensed beds exceeds 85% in urban areas and 75% in rural areas; or, a state establishes a capital spending review program for fixed assets subject to limitations of approval on capital-related items (other than moveable equipment) and a plan to identify hospitals to be closed. In addition, capital payment for moveable assets would be incorporated into DRG rates over a three year phase in period.

Critique

By incorporating moveable assets into the DRG rate, the bill creates an even greater incentive to move expensive technology out of the hospital to physician offices or outpatient centers paid for under Part B, the fastest rising component of the Medicare program.

The proposed capital expenditure limit by state would severely and arbitrarily cripple the ability of states with rapidly growing populations or with significant shifts in population among different regions to make adequate provision for future needs. Furthermore, in states above the limit, hospitals with substantial renovation needs would be prevented from meeting them.
Surplus beds are not a significant contributor to the increase in Medicare capital costs:

1) Since 1983 the number of community hospital beds has declined from 1,018,000 to 958,000 in 1987. Occupancy has declined because of fewer inpatient days not because of more beds.

2) Average occupancy as measured understates true community use. Like an electric utility, a hospital must be able to accomodate peak loads. Specifically, hospital occupancy during the week is considerably higher than average occupancy because of the trend toward trying to minimize unnecessary operating charges by keeping people out of the hospital over the weekend. Also, hospitals must be prepared to accomodate seasonal fluctuations in demand as well as day to day variations.

3) Occupancy rates based on inpatient days also understate actual facility utilization because a significant portion of a hospital's space is dedicated to serving the testing, procedure, and recovery needs of outpatients. According to the latest information available from the American Hospital Association's National Panel Survey (October 1988), occupancy adjusted for equivalent inpatient days resulting from outpatient visits was 81%.

4) Medicare does not pay for any extra operating costs incurred as the result of surplus beds, and the capital costs associated with empty beds have already been incurred and therefore cannot be changed. Empty beds have almost no effect on <u>incremental</u> capital costs.

5) The increase in Medicare payments for capital has very little to do with low occupancy. The main reason why capital costs have been rising rapidly is that hospitals have been aggressively adding new technology in response to demands from physicians and patients.

<u>Low occupancy does not produce higher costs</u>.

1) The hospital occupancy adjustment concept is based on an assumption that is not supported by the data, namely, that higher occupancy is associated with lower cost. The top 10 states by hospital occupancy in 1986 had <u>higher</u> revenues per case and per capita than those states that would be most affected by occupancy adjustment legislation.

COMPARISON OF AVERAGE REVENUES PER CASE—
HIGH OCCUPANCY VERSUS LOW OCCUPANCY STATES, 1986

Ten States With Highest Occupancy Rates (Average Occupancy Rate - 75.3%*)	Ten States With Lower Occupancy Rates** (Average Occupancy Rate - 60.6%*)
Revenues Per Case	
$4947	$4376
New York	Texas
New Jersey	Arkansas
Rhode Island	Louisiana
Hawaii	Mississippi
Maryland	Indiana
Connecticut	Arizona
Pennsylvania	Missouri
Massachusetts	Ohio
Vermont	Illinois
Deleware	North Carolina

*Occupancy rates weighted by inpatient days.
**Other more rural states have lower occupancy rates, but we exclude them because we assume hospitals with less than 50 beds would be exempt.

2) Legislation to reduce Medicare capital payments to low occupancy hospitals will redistribute Medicare capital payments to high cost hospitals in the northeast from lower cost hospitals in the midwest, south, and southwest. New York, for example, has the highest occupancy rate in the nation - 81.4% - versus 62.3% for California. Yet in 1986 New York's hospital revenues were 16% or $99 per capita higher than those in California. And, New York hospitals' revenues per capita have been growing faster - at an annual rate of 8.2% over the 1983-86 period versus 4.4% for California. New York also has immense hospital capital needs, the result of years of stringent government capital controls.

Average Annual Percent Change in Revenues per Capita

	1983-84	1984-85	1985-86	Average 1983-86
California	4.1	5.9	3.2	4.4
New York	9.7	6.3	8.6	8.2

3) An occupancy adjustment could increase Medicare's capital payments. Low occupancy hospitals typically are small and unlikely to have a full complement of sophisticated technology. Consequently, they tend to have below average capital and operating costs per case. If Medicare patients formerly admitted to these hospitals were treated in larger, more technology-intensive hospitals with much greater capital and operating costs, Medicare would pay more.

4) Penalizing hospitals for reducing length of stay, which has lowered occupancy, would reverse the incentives of the Prospective Payment System (PPS) which has dramatically slowed the growth rate of Medicare hospital expenditures. As noted in a Prospective Payment Assessment Commission (ProPAC) staff paper,

> PPS has encouraged hospitals to reduce lengths of stay, which has resulted in lower occupancy rates. An occupancy adjustment to PPS payments could undermine this incentive and penalize hospitals for responding to PPS. PPS already disadvantages low occupancy hospitals because it is a volume-based payment system. Declines in Medicare admissions have reduced the payments that low occupancy hospitals receive under PPS. Finally, capital is currently reimbursed at less than full costs, further discouraging unneeded investment.

5) Even if hospitals meet legislatively set occupancy targets by closing beds, Medicare's capital payments will not necessarily decline because allowable plant and equipment costs under Medicare are not mainly dependent upon the number of hospital beds licensed, certified or set up. Rather, they are based on the actual capital expenditures incurred by the hospital, the great bulk of which are used to upgrade the ancillary and outpatient services.

6) Low occupancy hospitals have little flexibility in reducing either capital or operating costs to offset lower capital payments from an occupancy adjustment. Most of the costs of an empty bed are fixed, e.g., mortgage payments, and cannot be changed; the out-of-pocket costs for closed beds such as custodial services and utilities are minimal. In response to Medicare payment updates far below cost increases, low occupancy hospitals already have cut their operating costs as much as is clinically prudent. Consequently, there is little if any opportunity for a hospital to cut costs even further.

7) An occupancy adjustment is an attempt to control Medicare outlays by controlling bed supply. As has been reported by the Federal Trade Commission (FTC), the evidence is strong that bed supply regulations have a long history of failure. Specifically, the FTC reported that its study "found no evidence that (Certificate of Need) programs have led to the resource savings they were designed to promote, but rather (it) indicates that reliance on CON may raise costs."

8) Occupancy rate targets set by regulation are inherently arbitrary and unfair because even a large number of occupancy targets cannot possibly accomodate the great variety of local area circumstances that may necessitate a low average occupancy rate. Hospitals in resort areas, for example, require significant reserve capacity as do hospitals in rural areas where demand can fluctuate widely. Hospitals in rapidly growing areas may have low occupancy today but will be almost full in a few years. A high, fixed occupancy rate could lead to not enough capacity or the wrong capacity in the wrong place.

Comments on Representative Stark's Statement Accompanying His Medicare Capital Payment Legislation

1) "The bill is designed to limit Medicare's reimbursement of hospital capital-related expenses to support of only those institutions which are truly needed."

Allocation of capital by a state planning agency - as the legislation proposes - historically has led to a deterioration of a state's hospital stock or gross misallocations. The experience of New York is a case in point. New York hospitals used to be the envy of the nation. After about two decades of stringent health planning, New York city hospitals especially are dilapidated and shabby. Furthermore, the cost of renovation now is far greater than it would have been had the alleged expert planners not consistently denied 'prudent capital improvement programs in the past.

2) "Over the last 5 years ... expenditures by Medicare to reimburse hospitals for their capital expenditures rose 76%."

According to the Congressional Budget Office, Medicare capital payments rose from $3.0 billion in 1983 to $4.3 billion in 1988 - a 43% increase or a compound annual growth of 7.46%.

3) "...the Grace Commission estimated that each of these empty staffed beds cost $40,000 per year, a very conservative estimate based on 1979 costs."

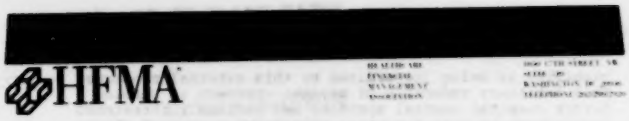
This estimate includes both capital and operating costs (the latter is over 90% of total cost), but operating costs associated with empty beds are not paid by Medicare since its DRG payment per case is fixed. The cost to Medicare is therefore limited to the capital payment (about $4488 per bed in 1988). The capital costs have already been incurred and will not go away regardless of whether Congressman Stark's legislation passes or not.

4) "Since a capital expenditure law (in Texas) was relaxed in 1985, nine new hospitals have opened. There is currently $1.5 billion in hospital construction in progress and occupancy rates in Houston have fallen from 75% prior to deregulation to below 60 percent today." This statement is a perfect example of why capital allocation decisions should not be made through the political system. Congressman Stark thinks that because Houston has gone through a depression because of declining oil prices, it should not be building hospitals. What he overlooks is that Houston is trying to make itself a national and international medical center and thus diversify its economy away from oil. If the Stark bill passed, Houston would be penalized for trying to stabilize and strengthen its local economy. While hospitals should be at risk for their capital decisions - no government bailouts for mistakes - they should have the authority to make their own capital investments since they are much better judges of need than state planners and are accountable for the financial outcome. The Stark bill in effect would enshrine the status quo.

5) "The high rate of excess capacity in beds and services leads directly to unnecessary admissions and procedures." This statement is contradicted by recent experience. Even though the total number of community hospital beds has been declining, occupancy has also declined. If hospitals could easily induce extra admissions, occupancy would have gone up not down as the number of beds went down. Peer Review Organizations (PROs) have been effective in controlling admissions.

6) "The retrospective cost-based or cost passthrough system assures that hospital managers will be insensitive to interest rates or to less expensive alternative methods of financing.... cost based reimbursement includes strong incentives to begin new projects."

These comments are at best gross overstatements. With the average hospital losing money on Medicare and with patient margins approaching zero, no hospital can be insensitive to interest costs. Furthermore, since Medicare is paying only a fraction of its pro rata share of capital costs and since capital investments generate significant operating costs - <u>provided the facility is used</u> - no hospital administrator who wants to keep his job will undertake a capital investment program to provide services whose projected cash flow is not sufficient to cover financing and operating costs. Thus, when Congress keeps the increase in Medicare payment rates for operating costs chronically below the increase in hospital cost increases, it is de facto reducing hospitals' demand for capital.



STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES
ON
MEDICARE PAYMENT FOR HOSPITAL
CAPITAL EXPENSES
MARCH 13, 1989

SUMMARY

- Payment at less than cost for capital is counter-productive, leading to a serious decline in the country's hospital infrastructure. The Healthcare Financial Management Association (HFMA) believes that continued inadequate payments for Medicare capital will lead to the need for a massive Hill-Burton type program to meet the healthcare needs of future generations.

- Adequate overall Medicare payment rates are a necessary prerequisite to incorporating capital in prospective price setting (PPS) rates.

- Past efforts to appropriately reduce hospital occupancy should be applauded and not subjected to current or future capital payment penalties. Current occupancy rates are unrelated to capital obligations incurred in prior years.

ABOUT HFMA

HFMA is a professional membership association composed of over 26,000 individuals in 74 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA's members include representatives from all major types of hospitals: urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants, and investment bankers, as well as representatives of Blue Cross, commercial insurors, and others who pay for healthcare services. These are the individuals with primary responsibility for access to and use of capital and the fiscal health of hospitals and other institutional healthcare providers across the country.

CURRENT PAYMENT LEVELS FOR CAPITAL CARE ARE COUNTERPRODUCTIVE

The current level of Medicare capital payment was designed in large part to reach Federal budget deficit targets. This has seriously jeopardized commitments for capital prior to PPS.

Capital payment reductions imposed by Congress have directly caused bond downgrading for a significant number of hospitals. This is supported by our recent Hospital Industry Financial Report: 1983-1987 (pages 139-143 are attached). These bond downgradings directly increase cost to the Medicare program through increased debt service expenses. We have also been told anecdotally that several hospitals are in technical default on their bond covenants because of reduced Medicare payments. Many of these hospitals are efficiently run institutions whose fiscal

viability is being jeopardized by this external pressure. This arbitrary reduction of payment approach to curbing future hospital capital spending has seriously threatened fulfillment of past financial obligations, many of which were undertaken with appropriate certificate-of-need approval.

Of grave concern to HFMA, also supported by our recent Hospital Industry Financial Report: 1983-1987 (pages 76-77 attached), is the decline in this country's hospital infrastructure, which we believe has been caused by recent congressional decisions to make capital payments at less than cost. HFMA believes that continued inadequate payments will create such an erosion in the hospital infrastructure that future generations will be saddled with a massive Hill-Burton type program to meet their healthcare needs. Such massive rebuilding, at an exorbitant cost, must be avoided by maintaining reasonable current levels of payment for capital.

ADEQUATE RATES ARE A PREREQUISITE TO INCORPORATING CAPITAL IN PPS PAYMENTS

The PPS system has demonstrated its success in constraining hospital operating expenses. Under certain circumstances the PPS system can be expanded to incorporate capital costs. However, any attempt to do so without first establishing adequate rates would create serious flaws in the system, jeopardizing hospital operations as a whole. We also believe that the incorporation of capital into PPS must recognize the true nature of capital costs and the varying capital needs of individual organizations. We again emphasize -- adequate payment rates are the key to success in incorporating capital in PPS rates.

OCCUPANCY RATES HAVE NO BEARING ON COMMITTED CAPITAL COSTS

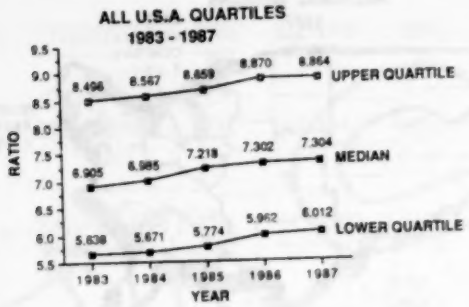
One of the major outcomes expected from the implementation of PPS was a decline in the number of hospital inpatient days used by Medicare beneficiaries. This change did occur, resulting in a dramatic decrease in hospital occupancy rates. Significant savings to the Medicare program for inpatient services has also occurred. This successful reduction in bed use, achieved by massive hospital management effort, should be applauded by Congress and others. Instead, hospitals have been subjected to outcries of inefficiency. The reality is that properly constructed financial incentives by government do work.

What must be recognized is that capital costs represent obligations that are long-term, generally committed prior to PPS or in its early phases, and remain constant regardless of the occupancy level of the institution. Therefore, attempts to tie occupancy to the amount of payment for capital is inappropriate and assumes a relationship that does not exist.

Attachments: Hospital Industry Financial Report: 1983-1987, pages 76-77, 139 and 143.

Capital. 9b

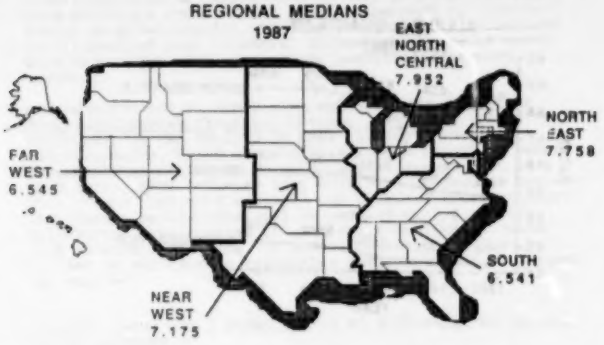
AVERAGE AGE OF PLANT RATIO



Discussion

- The average age of plant ratio provides a measure of the average age in years of the hospital's fixed assets. Lower values indicate a newer fixed asset base and thus less need for near-term replacement.
- Average age of plant ratios have been increasing for the last five years. In 1987, the median average age of plant ratio was 7.304. Appendix E further corroborates this point. In 1987, the percentage of fixed assets to total assets declined from 54.2 percent in 1983 to 48.9 percent in 1987. The hospital industry appears to be restraining its prior growth in new plant. This is most likely a result of declining utilization.

AVERAGE AGE OF PLANT RATIO



Discussion (continued)

- Sizeable regional differences exist. As most people would expect, the Northeast and East North Central regions have the oldest plants. In 1987, the East North Central region surpassed the Northeast as the region with the oldest physical plants. It is ironic that the two regions with the oldest physical plants seem to be in the worst position to correct their problem. Profitability is too low in these regions to enable reasonable replacement of aging physical plants.

- Rural hospitals have older plants than do urban hospitals. In 1987 the rural hospital average age of plant median was 7.96 years compared to 6.99 years for urban hospitals.

- Higher average age of plant ratios are negatively correlated with most measures of debt financing. This implies relatively older facilities have less debt which may mean that debt financing may be more readily available to meet their replacement needs, providing adequate debt service coverage can be documented.

STANDARD AND POOR'S RATING

	AA+ AA AA-	A+	A	A-	BBB+ BBB BBB-
PROFITABILITY					
DEDUCTIBLE RATIO	0.190	0.174	0.176	0.178	0.209
MARKUP RATIO	1.252	1.255	1.249	1.248	1.276
OPERATING MARGIN	0.031	0.037	0.026	0.023	0.019
OPERATING MARGIN (PRICE LEVEL ADJ)	-0.015	0.007	-0.003	-0.007	-0.010
TOTAL MARGIN	0.058	0.061	0.048	0.044	0.036
NONOPERATING REVENUE	0.393	0.303	0.378	0.320	0.421
REPORTED INCOME INDEX	0.800	0.960	0.966	0.962	0.999
RETURN ON TOTAL ASSETS	0.056	0.057	0.042	0.037	0.033
RETURN ON INVESTMENT (PRICE LEVEL ADJ)	0.085	0.094	0.081	0.079	0.078
RETURN ON EQUITY	0.129	0.120	0.094	0.094	0.081
GROWTH RATE IN EQUITY			0.103	0.100	0.091
LIQUIDITY					
CURRENT RATIO	1.574	1.646	1.889	1.783	1.784
DAYS IN ACCOUNTS RECEIVABLE	59.606	61.646	59.525	58.811	61.878
AVERAGE PAYMENT PERIOD	55.595	51.563	51.235	53.443	53.911
DAYS CASH ON HAND	16.355	10.911	13.371	12.403	13.143
CAPITAL STRUCTURE					
EQUITY FINANCING	0.512	0.504	0.423	0.382	0.346
LONG TERM DEBT TO EQUITY	0.534	0.685	0.997	1.254	1.446
FIXED ASSET FINANCING	0.433	0.478	0.619	0.656	0.932
CASH FLOW TO TOTAL DEBT	0.106	0.076	0.104	0.125	0.114
CAPITAL EXPENSE	0.074	0.078	0.089	0.083	0.087
TIMES INTEREST EARNED	2.484	2.962	2.727	2.182	2.183
DEBT SERVICE COVERAGE	3.166	4.156	3.104	2.755	2.641
LONG TERM DEBT TO DEPRECIATION	6.317	7.458	10.139	11.730	13.849
ACTIVITY					
TOTAL ASSET TURNOVER	0.966	0.937	0.862	0.829	0.791
FIXED ASSET TURNOVER	1.774	1.796	1.559	1.581	1.612
CURRENT ASSET TURNOVER	3.166	3.336	4.173	4.163	3.972
INVENTORY RATIO	67.033	90.284	67.017	73.964	61.250
OTHER RATIOS					
AVERAGE AGE OF PLANT	7.402	6.792	6.411	6.707	6.591
RESTRICTED EQUITY	0.092	0.128	0.022	0.026	0.000
REPLACEMENT VIABILITY	0.366	0.435	0.477	0.443	0.533
FINANCIAL FLEXIBILITY INDEX	-1.987	-1.477	0.132	-1.031	-2.249
MEDIAN BEDSIZE	483	483	311	250	100
NUMBER OF HOSPITALS	33	140	241	107	129

TIS

1987

STANDARD AND POOR'S RATING

	AA+ AA AA-	A+	A	A-	BBB+ BBB BBB-
PROFITABILITY					
DEDUCTIBLE RATIO	.188	0.202	0.210	0.219	0.218
MARKUP RATIO	1.352	1.314	1.308	1.297	1.290
OPERATING MARGIN	0.047	0.043	0.036	0.026	0.019	120
OPERATING MARGIN (PRICE LEVEL ADJ)	-0.0[illegible]	0.021	0.008	0.007	0.001
TOTAL MARGIN	0.059	0.056	0.048	0.042	0.036
NONOPERATING REVENUE	0.339	0.305	0.354	0.272	0.307
REPORTED INCOME INDEX	0.891	0.990	0.989	0.990	1.000
RETURN ON TOTAL ASSETS	0.046	0.046	0.039	0.033	0.028
RETURN ON INVESTMENT (PRICE LEVEL ADJ)	0.088	0.106	0.097	0.099	0.092
RETURN ON EQUITY	0.[illegible]	0.095	0.083	0.085	0.072
GROWTH RATE IN EQUITY	0.100	0.[illegible]9	0.078	0.087	0.093
LIQUIDITY					
CURRENT RATIO	1.827	2.[illegible]54	2.087	1.910	1.955
DAYS IN ACCOUNTS RECEIVABLE	74.203	67.893	69.077	70.211	67.337
AVERAGE PAYMENT PERIOD	62.4[illegible]	65.820	64.273	61.086	58.555
DAYS CASH ON HAND	20.[illegible]2	20.518	27.547	21.885	24.770
CAPITAL STRUCTURE					
EQUITY FINANCING	0.58[illegible]	0.486	0.481	0.431	0.385
LONG TERM DEBT TO EQUITY	0.4[illegible]0	0.727	0.817	0.921	1.255
FIXED ASSET FINANCING	0.[illegible]0	0.[illegible]1	0.752	0.843	0.842
CASH FLOW /[illegible] TOTAL DEBT	0.238	0.[illegible]03	0.177	0.158	0.112
CAPITAL EXPENSE	0.074	0.105	0.[illegible]	0.124	0.132
TIMES INTEREST EARNED	3.986	3.033	2.417	1.938	1.748
DEBT SERVICE COVERAGE	4.424	3.396	2.967	2.353	2.180
LONG TERM DEBT TO DEPRECIATION	6.484	7.796	8.212	8.685	10.249
ACTIVITY					
TOTAL ASSET TURNOVER	0.79[illegible]	0.802	0.77[illegible]	0.787	0.748
FIXED ASSET TURNOVER	1.[illegible]7	1.539	1.61[illegible]	1.65[illegible]	1.521
CURRENT ASSET TURNOVER	3.[illegible]07	3.450	3.3[illegible]	3.334	3.551
INVENTORY RATIO	78.[illegible]92	6[illegible].258	81.6[illegible]	79.662	67.567
OTHER RATIOS					
AVERAGE AGE OF PLANT	7.[illegible]5	6.[illegible]42	6.85[illegible]	6.832	6.581
RESTRICTED EQUITY	0.0[illegible]3	0.[illegible]07	0.011	0.017	0.003
REPLACEMENT VIABILITY	0.62[illegible]	0.[illegible]30	0.568	0.476	0.473
FINANCIAL FLEXIBILITY INDEX	1.780	171	1.794	0.042	-2.248
MEDIAN BEDSIZE	14	472	311	271	186
NUMBER OF HOSPITALS	23	[illegible]	186	81	88

143

Submitted to the Health Subcommittee of the House Committee on Ways and Means for inclusion in the record

STATEMENT OF THE

HEALTHCARE FINANCING STUDY GROUP (HFSG)*

ON H.R. 712

THE MEDICARE INPATIENT HOSPITAL CAPITAL EXPENDITURE AMENDMENTS OF 1989

I. INTRODUCTION

A recent article in a Massachusetts newspaper cites the Chairman-elect of the Massachusetts Hospital Association as stating that virtually every Bay State hospital will complete this fiscal year in the red. In addition, the testimony offered by the Hospital Association of New York on H.R. 712 suggests that the financial condition of hospitals in the empire state is almost as bad. Both jurisdictions have active state health planning laws requiring, among other things, review and prior approval of hospital capital expenditures. It might even be said that New York's Certificate of Need program is so effective in controlling the construction of unneeded beds that the state could qualify for the statutory exemption to the restrictions of H.R. 712 based on average hospital occupancy. Yet despite active Certificate of Need programs in both states and high average utilization rates in New York, the acute care systems of both are in distress.

II. COMMENTS ON THE PROPOSED LEGISLATION

H.R. 712 is a reasonable attempt to resolve a complex problem — the allocation of a limited resource (capital) in such a manner that duplication is avoided and service to underserved constituents is promoted. The strength of H.R. 712 is that it will force the most capable minds in this industry to focus on the issue of hospital capital expenditures and perhaps to stimulate a dialogue that will produce a comprehensive answer to the problem. As we see it, a flaw in H.R. 712 is its excessively heavy reliance on a resurrected piecemeal state-by-state health planning process that by most indices failed to accomplish the goals set for it by Congress in legislation enacted in 1974. The process was repealed in 1986 because of its ineffectiveness.

If the testimony submitted thus far on H.R. 712 proves anything, it is that complex problems require complex solutions. The health care delivery system addressed by the National Health Planning and Resources Development Act of 1974 (Public Law 93-641) was far less complicated than the post-competition, DRG-based delivery system that the implementors of H.R. 712 would face today. There are currently no clear distinctions drawn between acute care treatment modalities that are suitable only for the hospital

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* The Healthcare Financing Study Group (HFSG) is an organization founded thirteen years ago and made up of investment banks, law firms, accounting, feasibility and financial consulting firms, as well as bond insurers. HFSG's membership comprises virtually all the major firms in the tax-exempt bond industry, as well as most of the principal firms in other fields which have interests and responsibilities in connection with tax-exempt financing. HFSG closely monitors federal action as it affects capital cost reimbursement under Medicare and other issues including the certificate-of-need debate, caps on tax-exempt bond volume, DRGs, UBIT-related matters, legislation affecting HUD and HHS programs (those which provide health care facilities' mortgage insurance and refinancing insurance under Sections 242, 232 and 223 of the National Housing Act) and numerous other matters that affect tax-exempt financing for Section 501(c)(3) institutions.

operating room on the one hand and the outpatient setting or hospital-owned or affiliated ambulatory surgery center on the other. Health care in 1989 is approaching the realization of a continuum of care that ranges from the home setting to the hospital. Thus, any rational formula for the allocation of capital must be responsive to the changing character of hospital services.

Virtually all of the testimony on H.R. 712 implies that neither restrictive government regulation nor unbridled free market competition would provide a sensible formula for optimal hospital capital allocation. HFSG is in agreement with those groups who argue that capital distribution should be mainly market-regulated but overseen as necessary by state and federal agencies in their legitimate monitoring capacity in order to insure that all constituents are adequately served and excessive expenditures are minimized.

HFSG agrees with Congressman Stark's assessment that the Administration's proposal to limit Medicare capital payments for hospitals to 75 percent of incurred capital costs is inappropriate. However, HFSG disagrees with the key provision of H.R. 712 that would limit national annual capital expenditures for hospitals to a level at or below an arbitrarily set ratio based on historical capital and operating cost data.

H.R. 712 has as its primary objective the elimination of the federal subsidy of capital investment in unneeded acute care beds, as well as the fair distribution of capital assets to underserved (i.e., rural, urban poor and high AIDS incidence) communities. The bill would commit potentially hundreds of millions of Hospital Insurance Trust Fund dollars to induce states to return to the discredited health planning process. HFSG is of the opinion that such funding would be better devoted to creating incentive programs whereby the federal government would reward individual states with subsidies pegged to certain state-specific performance criteria.

In HFSG's view, states with strong health planning programs might become amenable to federal oversight due to the availability of federal financial incentives. For states lacking such programs, subsidies would obviously not be available and penalties such as denial of Medicare capital payments could be applied as proposed in H.R. 712. Rather than being conditioned solely on the existence of a state health planning program, however, the penalty could be imposed if some reasonable cap is exceeded in terms of annual hospital capital expenditures or if occupancy levels were to fall to some predetermined low level.

The benefits of a kinder, gentler H.R. 712 are manifold. First, competitive controls on capital are most reasonably imposed by giving the marketplace more time to adjust to relatively recent changes in hospital payment and service delivery methodologies, including HMOs and PPOs. Also, the more restrictive payment environment may well produce a hostile investment climate for new capital commitments for additional acute care beds in areas experiencing underutilization.

Second, the availability of capital could be further restricted through the development of new regulations to enforce Medicare fraud and abuse laws and possible legislative prohibitions on physician ownership of health facilities and equipment. As these changes are implemented, their effect could be monitored and an assessment made as to the necessity of further action before resorting to drastic measures such as a return to national health planning.

Finally, the use of available capital is likely to be far more responsive to the health care needs of local communities if the federal government allows maximum flexibility to the states to determine their individual health care requirements within the broad constraints of federal oversight.

Additionally, if H.R. 712 is to be approved by Congress as a necessary adjustment, it should first be modified to allow states to eliminate from their review process any capital undertakings that are accompanied by a public offering subject to federal and state securities laws. This would relieve the state review agencies of part of their burden, yet insure that some form of legally imposed review is done to test the

feasibility of individual projects. HFSG believes that the financial and legal disclosures and representations customarily required as part of a public offering would be adequate to safeguard against unnecessary (and hence unprofitable) hospital capital expenditures.

III. CONCLUSION

HFSG believes in the Congressionally ratified principle that the Medicare program should provide its fair share of necessary capital expense for new construction, renovation or replacement of acute care facilities. HFSG supports the inclusion of a capital cost add-on to the DRG rate for major medical equipment acquisitions by hospitals, with such add-ons to be made on an equitable basis to ensure reimbursement for necessary and proper costs related to such capital expenses. Finally, HFSG favors a market-regulated hospital capital expenditure program for facility construction, replacement, or renovation, subject to limited oversight by state and federal agencies to encourage proper resource allocation.

Edward Malmstrom
Chairman, HFSG
Merrill Lynch Capital Markets
212/449-3700

Dated: March 22, 1989

STATEMENT OF
SAINT ELIZABETH COMMUNITY HOSPITAL
RED BLUFF, CALIFORNIA

THE HOSPITAL AND ITS RELATION TO MEDICARE

St. Elizabeth Community Hospital ("St. Elizabeth") is a small 78-bed, general acute care hospital, located in Red Bluff, a city of approximately 9,500 in northern California that is being severely and unfairly penalized by a defect in the Medicare PPS reimbursement methodology. St. Elizabeth is designated as a Sole Community Provider ("SCP") under Medicare regulations because it is the only provider of hospital services in Red Bluff and for the surrounding rural area. As an SCP, St. Elizabeth is reimbursed under the Medicare Prospective Payment system ("PPS") as follows: 75 percent of its Medicare reimbursement is based on a hospital-specific rate calculated using historical hospital cost data and 25 percent of its Medicare reimbursement is based on what is telexed the federal portion of the DRG. As discussed below, this federal portion includes an adjustment for the appropriate Hospital Wage Index ("HWI").

St. Elizabeth is located in Tehama County, which is designated as a rural county. If the county were designated as urban, i.e., if it constituted or was within a Metropolitan Statistical Area ("MSA"), the HWI used in the federal portion calculation would be the HWI of the MSA. Instead, the federal portion of its PPS rate is computed using the average rural wage index for California.

THE PROBLEM

Tehama County, within which St. Elizabeth is located, is sandwiched between two MSAs: the Chico MSA (comprised of Butte County) and the Redding MSA (comprised of Shasta County). All hospitals within an MSA are reimbursed using a wage index calculated from data generated by the individual MSA. The Chico and Redding wage indexes are significantly higher than the statewide rural average wage index: the per-case labor component of the federal portion for Chico and Redding hospitals is $2,045.36 versus the rural statewide-labor component of $1,791.88, which is applied to St. Elizabeth -- more than a 14 percent differential.

Application of the statewide rural average is unfair to St. Elizabeth because it essentially pays urban wages. Because Red Bluff is a small town 45 miles north of Chico and 30 miles south of Redding, St. Elizabeth must compete with Chico and Redding hospitals for its employees. To compete with these hospitals, St. Elizabeth must pay similar wages. St. Elizabeth's pay scale is equal to that of the Chico MSA hospitals and within 10 percent of that of the Redding MSA hospitals.

Not only is St. Elizabeth being underreimbursed by having the rural, rather than urban, wage factor applied to it, but also St. Elizabeth's status as an SCP would prevent it from obtaining the full benefit of the urban wage factor if it were to be designated as "urban." Under the PPS reimbursement methodology, a reclassification from rural to urban would help a Sole Community Provider for only 25 percent of its reimbursement because SCPs are reimbursed at the following percentages: 75 percent, based on hospital specific costs and 25 percent, based on the federal portion. The reclassification would affect the federal portion. For a non-SCP, however, reimbursement is 100 percent based on the federal portion. Thus, if St. Elizabeth was redesignated from rural to urban, it would achieve the maximum benefits from that redesignation only if it also could receive the non-SCP reimbursement methodology. The combined effect to St. Elizabeth of being designated as rural rather than urban and of not being

allowed to receive 100 percent of federal portion, as non-SCP's receive, is a reimbursement decrease of approximately $800,000 per year from what it would receive if the foregoing problems were corrected. This, of course, is a devastating loss to a small 78-bed rural hospital.

St. Elizabeth could receive 100 percent of the federal share if it gave up its SCP status, but at this point that would appear to be forcing St. Elizabeth to a very unfair choice. From recent reports in the healthcare press, it appears that both Congress and HCFA may be preparing to increase protections to small rural hospitals and there may be new legislation or regulations very favorable to SCPs in the near future. In addition, it may be that St. Elizabeth's status as an SCP will lead to favorable treatment under the proposed new capital cost regulations. Moreover, it is virtually impossible for an SCP to regain that status, once having given it up.

CONGRESSIONAL POLICY

The devastating underreimbursement to a Sole Community Provider, as outlined above, was never intended by Congress. First, the purpose of the rural versus an urban wage rate factor is to shape reimbursement according to actual differences in wages. Congress never intended to penalize a rural hospital that must pay urban wages because it is sandwiched between MSA's. Second, Congress enacted the SCP designation in order to protect small rural hospitals from the "at-risk" features of the Medicare PPS system -- features which could allow a catastrophic loss to a small hospital. It was never the purpose, however, to "freeze in" a seriously disadvantageous wage formula. Finally, Congress has declared several times that small rural hospitals are entitled to special protection. It never intended that an SCP be required to give up that special status in order to achieve equitable reimbursement.

THE EXISTING RECLASSIFICATION PROCEDURE IS INADEQUATE

There is an existing method of reclassifying certain limited rural hospitals as urban, and thereby obtaining reimbursement using an urban wage index, but the criteria are extremely restrictive and could not be met by St. Elizabeth. The requirements for reclassification, set forth at 42 C.F.R. Section 412.63(b)(3), are as follows: (1) at least 95 percent of the perimeter of the rural county within which the hospital is located must be contiguous with urban counties, (2) the county within which the hospital is located must have been reclassified from an urban area to a rural area after April 20, 1983, and (3) at least 15 percent of employed workers in the subject county must commute to the central county of one of the adjacent MSAs. Very few, if any, rural counties can meet these requirements. Indeed, it would seem that these criteria were drafted with a particular county in mind. St. Elizabeth does not meet these narrow criteria.

The 1988 Reconciliation Budget Bill did include a provision aimed at alleviating the penalty suffered by rural hospitals which must pay urban wage rates. Unfortunately, this provision did not solve St. Elizabeth's reimbursement problem because it focused on the percentage of all workers commuting from adjacent MSAs to the subject county rather than hospital employees.

Section 9302(e) of the House Version of the 1988 Budget Bill (HR3545) would have rectified St. Elizabeth's Medicare reimbursement problem. Unfortunately, this provision was deleted in the conference committee which drafted the 1988 Budget Reconciliation Bill.

On January 31 (Legislative day, January 3), 1989, Senator Bentsen introduced S.306, a bill to amend the Social Security Act to make certain modifications in the Medicare program

with respect to payments made under such program to hospitals located in rural areas, to improve the delivery of health services to individuals residing in such areas, and for other purposes. That bill provides, among other things, for special payments to small rural hospitals with a high dependence on Medicare patients, use of more current cost data in calculating hospital-specific payments to SCPs and the creation of a geographic classification appeals board to hear requests by rural hospitals to receive payments at an urban rate. St. Elizabeth heartily concurs with both the spirit and letter of S.306, and applauds Senator Bentsen and his co-authors for recognizing that although the last year's Budget Bill provided some relief to rural hospitals, it by no means solved all of the problems of the rural hospital provider.

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STATEMENT OF SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC
BEFORE THE HONORABLE PETE STARK, CHAIR, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES
ON "MEDICARE INPATIENT HOSPITAL CAPITAL EXPENDITURES
AMENDMENTS OF 1989" - H.R.712
SUBMITTED BY: PEGGY CONNERTON, SEIU DIRECTOR OF PUBLIC POLICY

I would like to thank Representative Stark and the other members of the Subcommittee on Health for this opportunity to present the views of the Service Employees International Union on the Medicare Inpatient Hospital Capital Expenditures Amendments of 1989.

We support all responsible efforts to reform the health care reimbursement system. Our union is deeply concerned with the battle to contain the rapidly escalating cost of health care, both as consumers and as health care workers.

SEIU is the largest healthcare union in the United States, representing 300,000 workers in hospitals and nursing homes. Our members know first-hand that hospital workers and patients today carry the full burden of cuts in healthcare spending. Meanwhile, hospitals remain free to bill Medicare for the entire cost of building projects, remodeling, and new equipment. Doctors, too, can continue to charge excessive fees.

This anti-labor bias occurs because the current DRG system limits Medicare payments only for operating costs (largely labor). At the same time, Medicare continues to pay all capital costs (depreciation, interest, and rent) on a pass-through basis. This federal policy effectively transforms labor costs into a drain on hospital budgets, and capital into a revenue producer and generator of funds for expansion. Hospitals are encouraged to substitute capital for labor.

These are bizarre incentives in a system criticized for years for excessive spending on hospital facilities and equipment, yet, rarely, if ever, criticized for providing too much patient care, overly nutritious meals, or an excess of housekeeping staff and cleanliness. The end of certificate of need programs and health planning in many states is further fueling the health care industry's capital spending spree.

SEIU supports legislation to end this anti-labor bias by bringing capital costs into the prospective payment system. In the long run, healthcare cost containment will require that we control all sources of costs.

Capital-labor substitution

SEIU locals are seeing these perverse incentives played out in city after city. Hospitals impose wage freezes and lay off workers, while expanding and adding more expensive services--with little attention to whether the equipment will duplicate a neighboring hospital's facilities.

For example, SEIU Local 627 in Youngstown, Ohio faced an array of labor cutbacks at 3 non-profit hospitals -- including 250 layoffs, frequent double shifts for LPNs and nurse aides, and wage concessions. During this same period, the hospitals spent $16 million for among other things, cat scans, new outpatient surgery divisions and extensive building renovation.

Workers tell the same story at Serra Memorial Hospital in Sun Valley, California. The workers also faced layoffs and hiring freezes, while the hospital built a new lobby, a library, a doctors' lounge and an ER lounge.

SEIU DRG Survey

We can generalize these examples, based on a survey recently mailed to SEIU's 80 locals representing hospital workers. The survey asks locals to tell how DRGs affected wages, working conditions, services and patient care.

With a return rate of 25% of our locals covering roughly 30,000 SEIU hospital workers, the survey results best depict what is happening at a "typical" community hospital. (Table 1 shows the average bedsize, occupancy rates, and finances of the hospitals in our survey which match closely the average industry profile for community hospitals.)

The survey findings highlight the substitution of capital for labor. In hospital after hospital, staffing cutbacks stand side-by-side with new technology purchases and new construction. (See Table 2 for detailed results of the survey.)

For example, nearly 88% of the hospitals imposed hiring freezes on workers, and 53% reported that there were actual layoffs at their hospital. Over 60% of these gave precise figures on how many nurses, clerical workers, technicians, aides, orderlies and maintenance workers have been laid off as well as the number of positions lost through attrition. For those reporting exact figures, the layoffs on average wiped out over 10% of the workers in our bargaining units.

Hospitals have gone well beyond "trimming the fat". Over 67% of our surveyed members report that their units are now operating dangerously short-staffed thanks to current DRG incentives. At the same time, 75% reported their hospitals engaging in substantial new renovation and construction and 55% of the hospitals purchased major new equipment.

We're not saying that all this capital investment is unnecessary. Some of our inner city hospitals have badly outdated plant and equipment. However, it's hard to comprehend all this building in an industry saddled with excess capacity and duplicative technology. Because capital costs continue to be excluded from prospective payments, the system provides strong incentives for hospitals to overinvest in capital at the expense of workers.

Labor not driving hospital inflation

Since 1983, hospitals have laid off 140,000 workers nationwide. This sacrifice of workers comes in spite of ample evidence that labor costs do not account for run away health costs. Hospital workers' wages, adjusted for inflation, are barely above 1972 levels.

In fact, labor costs have taken a smaller and smaller bite out of total hospital budgets. From 1965 to 1985, payroll costs declined from 62% of total expenditures to 46%. This dramatic reduction occurred despite a 55% expansion in the number of employees per patient due to factors such as technological advances, a sicker patient mix and shorter hospital stays -- all requiring more intense levels of service.

Moreover, these are total payroll costs -- including supervisory, physicians, dentists, residents and interns salaries. Rough adjustments put nonsupervisory costs at less than 40% of total costs. This means that a 10% increase in the wages of nonsupervisory workers would produce less than a 4% increase in the costs per patient day, given the same level of services.

While labor costs have declined, capital costs are up. The national statistics confirm that the growth rate of capital costs continues to outstrip the increase in total costs -- despite the low interest rates the last 2 years. Capital costs in 1986 increased a whopping 10.8%.

Short staffing affects patients' care

Hospital workers say their staff have been cut so much that they cannot provide quality care. Understaffing is now common at every level of care. Since the advent of DRGs nursing staff report:

Lower staff to patient ratios which in many units nurses

feel are at dangerous levels. For example, 3 LPNs were responsible for a 44 patient surgical unit in one facility.

Incident reports completed daily by all nurses are more likely to cite problems attributed to poor staffing.

When staffing crises hit, hospitals are apt to use temps and float pools. As a result, nurses feel that inadequately trained people are placed in critical care areas and on other units where specialty training is needed.

Patient care staff are working extended shifts -- 12 and 16 hours a day.

Although nursing staff know intimately the impact on patient care, all staff levels have been affected by cuts. Our survey shows that the number of other support staff -- particularly the aides and orderlies who are responsible for turning, lifting, bathing and feeding patients -- have been cutback to levels where patients are forced to wait longer for staff attention, where the ambulatory patients must often fend for themselves, and when, finally, many patients are not getting the care they need.

Cutbacks in housekeeping and maintenance means that linen and supplies are often not available when and where they are needed. Hospital cleanliness has also suffered. Our housekeeping workers report that since DRGs were imposed they must clean more square feet of space per day and have been instructed to clean some areas less frequently.

For example, at McKeesport Hospital in Pennsylvania, the nursing staff has shrunk from 450 non-supervisory positions to 386 since DRGs started. Nurses are so busy thanks to higher patient to staff ratios that patients are not getting changed and call-buttons go unanswered.

At Youngstown Hospital, workers report numerous incidents of their inability to provide adequate levels of care to patients due to understaffing. In one case, aides were so over worked that a patient who had an IV in one arm was given a wash cloth and asked to bathe himself. Another case found a kidney dialysis patient with vision complications not provided with aides to help with meals. Furthermore, this individual was left on several occasions to administer her own eye medication.

At the Serra Memorial Hospital in California, understaffing is a particularly severe problem in critical care units with several violations noted by inspectors.

Conclusion

The time has come to end the anti-labor bias in the current DRG system by bringing all hospital expenses under control. As a first step, we would support legislation along the lines suggested by the Prospective Payment Assessment Commission. They recommend phasing-in capital and operating costs into a single all-inclusive prospective payment per case. However, we would like to see the phase-in period shortened somewhat.

In general, the nation must focus its efforts to contain health care costs resulting from waste, duplication of services and ineffective care. If we, instead, make it impossible for over-worked, underpaid hospital staff to deliver compassionate health care, we all will suffer.

Health care without investment in people is simply not care.

TABLE 1. DRG SURVEY - SAMPLE CHARACTERISTICS

FACTS ON STAFF REDUCTIONS

	Average	Range
LAY-OFF RATE	10.5% *	2.5% - 35.8%
ATTRITION RATE	6.6% *	3.3% - 11.1%

* Represents percent reduction in bargaining unit staff.

Source: S.E.I.U. Survey - "The Impact of Diagnostic-Related Groups on Hospital Workers and Patients".

PROFILE OF HOSPITALS SURVEYED

	Average	Range
OCCUPANCY RATE	64.4%	33.3% - 82.1%
BED SIZE	255	63 - 1240
PROFIT RATE (Total net margin)	5.87%	.92% - 13.2%

Source: "Economic Trends", American Hospital Association, (December, 1985).

TABLE 2. DRG'S RAISE HOSPITALS' CAPITAL SPENDING AT EXPENSE OF HOSPITAL WORKERS

Staff Reductions	No. of Hospitals	Percent of Total Hospitals
Chronic Staffing Shortages	35	87.5 %
Hiring Freezes/Attrition	35	87.5 %
Not Replacing Absent/On Leave Workers	27	67.5 %
Increased Floating Assignments/Temporary Personnel/Contracting Out	26	65.0 %
Increased Part-time Work/Job Sharing	23	57.5 %
Lay-offs	21	52.5 %

Capital Investments	No. of Hospitals	Percent of Total Hospitals
Major Renovation/New Construction	30	75.0 %
Major Purchases of New Equipment (i.e. CAT/nuclear scanners)	22	55.0 %

Source: Service Employees International Union Special Survey- "The Impact of Diagnosis-Related Groups (DRG's) on Hospital Workers and Patients".